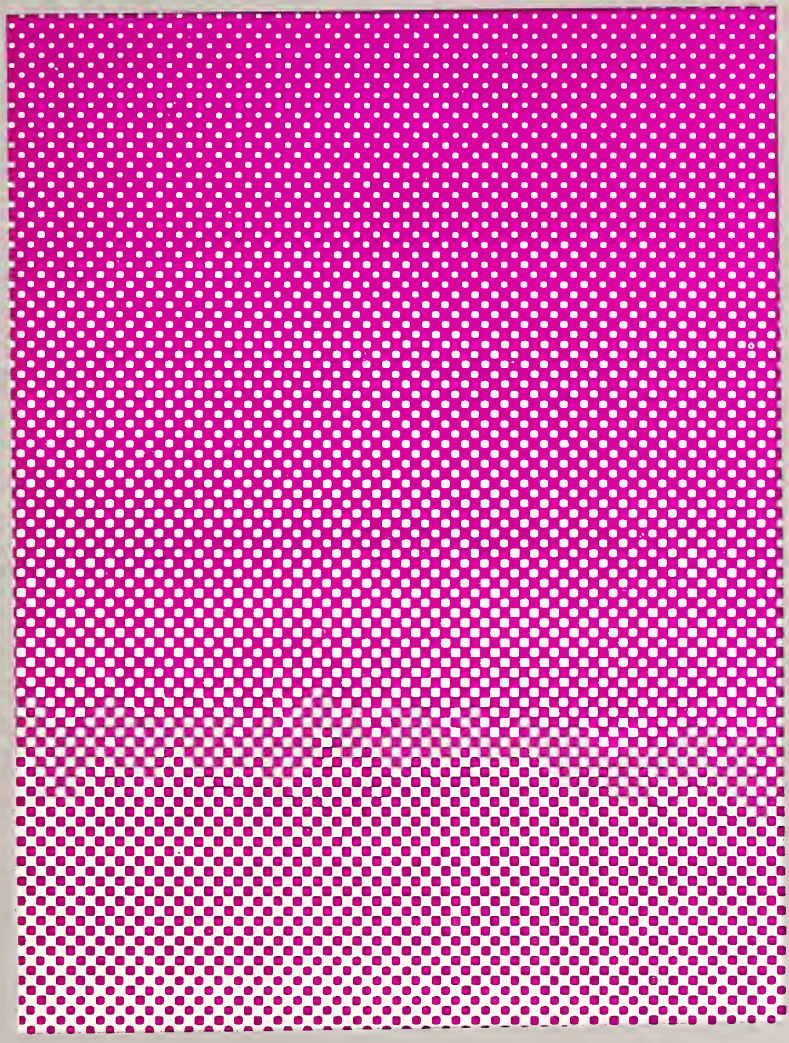
MEDICARE HOSPITAL MORTALITY INFORMATION



Volume VII

Texas – Guam

U.S. Department of Health and Human Services
Health Care Financing Administration

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MEDICARE HOSPITAL MORTALITY INFORMATION

1986

VOLUME VII

TEXAS - WYOMING

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The Health Care Financing Administration (HCFA) was established on March 9, 1977, to combine health financing and quality assurance programs into a single agency. HCFA is responsible for the Medicare program, Federal participation in the Medicaid program, the Peer Review Organization program and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to ensure the effective administration of our programs in order to promote the timely delivery of appropriate, quality health care to over 56 million of the nation's aged, disabled and poor. The agency must also ensure that beneficiaries are aware of the services for which they are eligible, that those services are accessible and of high quality and that agency policies and actions promote efficiency and quality within the total health care delivery system.

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The Administrator
Washington, D.C. 20201

INTRODUCTION

The nation's Medicare program, which is administered through the Health Care Financing Administration (HCFA) of the Department of Health and Human Services, now has 31 million beneficiaries. One of HCFA's primary responsibilities is to ensure that Medicare beneficiaries receive quality health care. We believe that the publication of the information contained in this document will contribute to that end.

This particular information release, presents information to answer the question: "What is the actual death rate for each hospital compared to what would have been expected for that particular hospital given what we know of the characteristics of patients admitted?" The statistics are presented in the hope that they will serve the public and the hospitals in their common interest of improving quality of care.

The development of mortality statistics is a complicated and controversial task since the mortality rate at a given hospital reflects, among other factors, age, sex, diagnosis, and severity of illness of patients admitted to that hospital, as well as the purpose and quality of the care they received. Characteristics affecting health and the probability of death vary among the patient populations served by individual hospitals. Consequently, the mortality rates in different patient populations will vary.

The usefulness of this information depends upon the accuracy with which mortality rates can be predicted and the stability of these rates over time for each hospital. It is important to understand that the predicted values in the tables contained in this document are not a direct measure of the quality of care rendered in hospitals. There is one primary reason for this. We do not now have any direct measurement tool with which we can adjust fully for differences among hospitals in how severely ill their patients are. For instance, two hospitals might have very different death rates for patients admitted for stroke, even after we have adjusted for age and sex. This might happen because one hospital's stroke patients consist of a significant number admitted in a coma and are thus likely to die, whereas another hospital's patient population represents a broader spectrum of patients with cerebrovascular problems, or because these hospitals in fact provide different levels of quality. In addition, other factors affecting the probability of death in a particular case, e.g., family status/support, and overall health status are not included in the predictive model because information on them is not readily available.

When properly understood and used, this information can be useful; it can also be very misleading if it is interpreted incorrectly. The information simply describes one aspect of individual hospital performance--post admission mortality for Medicare beneficiaries. The information is not necessarily representative of a hospital's total performance in all aspects of patient care, and is best used to view experience in individual hospitals rather than making comparisons among hospitals. Individual hospitals may have very good reasons for their rates being higher than the ranges predicted by HCFA's model. Accordingly, it was important for hospitals to have an opportunity to review their specific information and to provide comments to HCFA and the public. We asked each hospital to prepare its comments on the information being released to the public, and we are including those comments in this publication.

The information is an important contribution to the health care community and should be reviewed by a wide range of individuals and organizations including hospital administrators, Peer Review Organizations, physicians and researchers. Among these audiences, perhaps the hospital administrator will find the information most useful--as a screening tool and in consulting with medical staff to evaluate a hospital's strengths and weaknesses. In this way, the information should lead to analysis and subsequent actions which will capitalize on areas of strong performance and strengthen areas where improvement is needed. For example, we expect that hospitals and their medical staffs, using established and newly emerging quality assessment techniques, will try to determine what useful information can be derived about how they function.

Consumers should read the explanations of the uses and limitations of the information, as well as any comments a hospital may have provided, and should carefully consider the different roles that different hospitals play in their community. For example, one hospital might have different death rates than another because it serves more severely ill patients, because it specializes in difficult illnesses, or because it is a trauma or emergency center.

The development and presentation of this information is an important part of HCFA's responsibilities in the health care community, and follows nearly a full year of effort. In making the information as accurate and useful as possible, we discussed the theoretical framework and statistical approach with a number of national experts in appropriate fields. As a result, we believe the models used in this work are reasonable and appropriate for the intent of the publication. In addition, the format for presentation, the process for sharing the information with individual hospitals, and the statistical methodology have been discussed at a series of meetings with leaders of organizations representing Medicare beneficiaries, doctors and hospitals, and a great many suggestions from these groups have been incorporated into the final approach.

We are continuing to do everything we can to make these types of information more useful to both the public and the health care professions. We are refining ways to use the information as a screening tool for "quality of care" purposes, and we are developing tools to adjust for the differences in disease severity highlighted earlier. In addition, because we recognize that mortality rates alone do not adequately measure how effectively a hospital cares for its patients, we will be developing other measures of outcome, such as the kind of medical treatment needed after discharge, to assess the performance of hospitals more fully.

We have begun what will be a continuing effort involving all interested parties to improve the accuracy of outcome predictions by refining the model and the methodology. This will contribute to assessment of and improvement in the effectiveness of medical services.

William L. Roper M.D.

William L. Roper, M.D.
Administrator

DESCRIPTION OF INFORMATION

Before reading the tables containing the hospital specific information and the comments provided by individual hospitals, it would be useful to understand the format and presentation of the information in this document.

The information is presented in alphabetical order by state and by hospital within the state. For each hospital, information is presented for overall Medicare patient mortality and each of 16 diagnostic categories. The information consists of the number of Medicare patients, the actual mortality rate, and a range of predicted mortality given the mix of patients. It would be helpful to describe how the numbers were derived and what they represent.

- Number of Patients. This figure represents the number of individual Medicare beneficiaries whose last discharge from a short term, acute care hospital in 1986 was from the hospital listed. The total number for each hospital is presented under the category "overall." Similarly, for each diagnostic category, the number of patients consists of the number of Medicare beneficiaries whose last discharge in 1986 was from the hospital cited and whose primary diagnosis fell within the specific diagnostic category. (Generally the number of patients in the sixteen diagnostic categories will total between 70 percent and 80 percent of the figure for "overall." The remaining 20 percent to 30 percent represent diagnoses that do not fall within the 16 diagnostic categories specifically studied.)

  Since only a patient's last hospital discharge is "counted" in the total number, HCFA's computation and that maintained by individual hospitals will generally differ. For example, if John Doe was a patient at Hospital A three times during 1986, the methodology used in HCFA's analysis counts only the last admission in the hospital's total. Normally a hospital will maintain statistics based on numbers of admissions and so would count Mr. Doe as three cases. In addition, in this example, if Mr. Doe were admitted later in the year to Hospital B (another acute care hospital) and then discharged in 1986, and this latter stay represented his last discharge for 1986, his case would be counted in Hospital B's total and he would not appear at all in Hospital A's count.

  The key factor to remember is that we are examining last hospital discharges in 1986. In some cases, this will necessitate the inclusion of patients admitted to the hospital in December 1985 or those who died in January 1987.

- Actual Mortality Rate. This figure presents the percentage of each hospital's Medicare patients who died within 30 days of the admission that resulted in the last-occurring discharge of the patient in 1986. (The percentage is rounded to the nearest whole percentage point.)

  Where, for example, Hospital A had a universe of 1000 patients whose last acute care hospital discharge in 1986 was from Hospital A, and 100 of these patients died within 30 days of that last admission, whether as hospital inpatients or after discharge, the actual mortality rate would be 10 percent. This rate includes cases in which a beneficiary was admitted to the hospital in 1985, was discharged in 1986 and died within 30 days of admission. It also includes those instances in which a beneficiary was discharged in 1986 and died within 30 days of admission even though the 30 day period extends into 1987. Cases in which the beneficiary was not discharged in 1986

are not part of the rate, even though an individual may have died in 1986 or have died within 30 days of last hospital admission. For example, a person admitted to a hospital on December 20, 1985, who was discharged on December 30, 1985 and who died on January 2, 1986 is not part of the calculation since the person was not discharged in 1986. Similarly, a person admitted to a hospital on December 28, 1986 who was discharged on January 5, 1987 and died on January 8, 1987 would not be a part of the calculation even though he or she died within 30 days of a 1986 admission.

- Range of Predicted Mortality. This column gives an estimate of mortality rates for patients equal in number and similar in characteristics to those treated by the hospital. The range is derived in part by determining, based on national experience, the relative risk of dying associated with various patient characteristics: previous hospital admission(s), transfer status, age, sex, and presence of up to eight comorbid conditions (cancer, cardiovascular disease, cerebral degeneration/psychosis, pulmonary disease, renal disease, liver disease, diabetes, hypertensive disease) and by applying weights of the risk factors to the actual number of patients at the hospital to enable compilation of an expected mortality rate. This rate is converted, through statistical techniques, to a range of predicted mortality rates. It is important to note that the fewer the number of cases included in a given diagnostic category, the greater the uncertainty of the expected mortality range, and therefore, the wider the range. A larger number of cases yields greater precision, and therefore, a more narrow range of predicted mortality rates.

HOSPITAL COMMENTS

On September 21, 1987, HCFA mailed to each hospital its own mortality information and asked for comments by October 28, 1987. These comments are arranged alphabetically by state and are included in this publication immediately after the tables presenting information for all the hospitals in a given state. The entry for each hospital on the state charts indicates where to find the hospital's comments and presents a notation (asterisk) advising of the absence of hospital comments. The page number where the comments of the hospital are presented is given next to the name and address of the hospital.

The comments are generally reproduced as submitted by the hospital. However, some hospitals returned to HCFA, an annotated copy of the information sent on September 21. These annotated materials have not been reproduced in this publication, even in those instances where they were the only form of comments submitted by a hospital. The reason for not printing these materials is one of privacy. Information which would identify or possibly identify patients must be deleted, and consequently any remaining information would be very confusing and of extremely limited use, if not totally useless. Therefore, we have included a statement to identify instances when these types of materials have not been included. As mentioned earlier, it is extremely important that the information presented in the tables be reviewed in concert with the hospital's comments.

In any project of this size, there will be instances where hospitals did not receive the information for comment or did not receive it timely. In fact, many hospitals were sent second copies of their specific information in an expeditious manner to allow every opportunity for review/study and comment. Although we have received over 2,600 comments out of a possible 5,971, it is possible that some of the non-responding facilities never got the information or did not have adequate time to comment. However, we expect these instances were few in number.

INFORMATION SOURCES AND NOTES

It is important to note that this publication is based primarily on analysis of Medicare hospital billing information for calendar year 1986. While information about beneficiaries, was obtained from the Social Security Administration (SSA), the principal source for the analysis was the HCFA maintained MEDPAR file which contains information about each Medicare hospitalization. Hospitals submit such information to HCFA's fiscal intermediaries (which pay hospitals for the care provided to Medicare beneficiaries). The file is updated quarterly. It is estimated that billing information on approximately 95% of all Medicare discharges is included in the MEDPAR file within 6 months of the close of the calendar year. Accordingly, our analysis was based on information received through June 30, 1987.

In any large scale data base such as one dealing with Medicare hospitalizations, there will be gaps or inaccuracies. The fact that the files contain information on about 10 million hospital admissions to nearly 6,000 hospitals provides some assurance that for purposes of the statistical analysis conducted here, the information which might be missing or inaccurate is such a small portion of the total that it would have almost no impact on the results.

Nonetheless, while we feel that the information used in this analysis is quite thorough and complete, there are a few points which should be kept in mind as the hospital specific information is being reviewed.

- The information used is billing data and is only as good as the information submitted by hospitals as a part of the payment process. Although there is always a possibility that coding errors are included, the assumption is that hospitals do not make errors on billing forms which ultimately affect payment to them. Likewise, it is assumed that given the link to payment, hospitals have an incentive to submit bills promptly.

- The hospitals included in this analysis are short-term, acute care facilities which were identified by their unique provider number. All facilities which have a zero in the third column of their provider number are by definition participating in Medicare as short-term, acute care facilities. All other facilities--those with something other than a zero in the third column of the provider number--were excluded from the analysis. In some cases, hospital names suggest an orientation different from acute care. This does not mean the facility is inappropriately included in the publication.

- There is some information in the file which does not reflect the results of review by Peer Review Organizations (PROs), the entities charged with reviewing hospital services provided to Medicare beneficiaries. For example, one of the functions a PRO performs is to ensure that the diagnosis assigned to a particular case is accurate. The nature of the review and payment system is such that it is possible for PRO changes in diagnosis assignment not to be submitted to HCFA and associated in the MEDPAR file on as timely a basis as other billing information. Obviously, any major changes in diagnosis assignment which are not reflected in the data base would have a bearing on calculation of mortality rates in individual diagnostic categories and may also have a bearing on the extent to which presence or absence of comorbidities has been reflected accurately.

Some hospitals pointed out instances where the hospital's information did not agree with HCFA's, e.g., different date of death, cases of subsequent admission to another facility, or changes in diagnosis codes. The data base used in this analysis has not been revised to reflect these potential discrepancies. Rather we are examining all hospital comments to ensure that changes to our data systems and processes can be made when warranted so that future releases will be even more accurate. Readers are urged to review any hospital comments with a specific view toward these types of issues.

- The predictive model used in this effort does not explain all variability in outcome. Most notably, a measure of severity of illness has not been included in the model, and therefore, the predictive power of the model is less precise than it would be if such a measure had been available. Nonetheless, the information included in this document does legitimately contribute to the body of information about hospital performance.

Texas

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALICE PHYSICIANS & SURGEON ALICE TX 78332	TX-39	660	13	10-18	11	18	7-57	24	33	15-52	22	27	6-40	46	22	14-40	23	57	24-63	17	18	3-41	85	16	12-31
ALL SAINTS EPISCOPAL HDSP FDRT WORTH TX 76104	TX-40	3677	10	9-15	329	19	16-31	96	24	20-40	87	17	9-28	188	22	16-30	129	32	30-49	72	28	15-38	246	15	13-26
AMI ALVIN COMMUNITY HDSPIT ALVIN TX 77511	TX-41	355	18	11-20	18	28	7-46	20	30	14-53	9	11	5-57	21	43	10-46	17	29	18-62	12	17	8-57	49	35	13-38
AMI BELLAIRE HDSPITAL HDUSTDN TX 77081	TX-42	534	17	10-18	20	30	11-49	5	40	5-73	21	29	7-43	33	18	12-42	12	33	16-67	28	11	7-39	76	36	14-35
AMI COASTAL BEND HDSPITAL ARANSAS PASS TX 78336	TX-43	570	15	10-18	23	35	9-45	29	24	14-47	12	42	5-50	24	17	9-42	37	35	27-58	14	29	5-47	48	25	12-37
AMI DENTDN REGIDNAL MEDICA DENTDN TX 76201	TX-44	1145	13	10-17	87	24	18-40	58	21	19-44	24	17	6-39	50	30	15-39	45	31	25-54	42	19	9-37	117	28	13-30
AMI FORT BEND COMMUNITY HO MISSOURI CITY TEXAS 77459	TX-45	220	15	9-19	7	14	6-66	13	54	13-60	6	17	2-64	18	17	6-43	10	50	14-68	10	30	4-55	18	6	7-44
AMI HEIGHTS HOSPITAL HOUSTDN TX 77008	TX-46	1204	13	9-16	104	18	12-31	45	38	18-45	41	12	6-30	52	25	14-37	31	42	24-58	63	32	10-34	84	27	12-30
AMI KATY COMMUNITY HDSP KATY TX 77540	TX-47	397	17	11-21	15	20	8-51	16	19	13-57	15	33	6-47	16	38	9-51	23	39	19-57	17	24	10-52	45	33	13-39
AMI MEDICAL ARTS HDSPITAL DALLAS TX 75235	TX-48	96	0	2-14	4	0	1-74	1	0	0-97	2	0	1-89	1	0	0-98	1	0	2-98	.	.		5	0	2-68
AMI PARK PLAZA HOSPITAL HDUSTDN TX 77004	TX-49	1768	9	8-14	134	10	14-32	43	35	17-44	35	17	8-35	74	15	14-33	34	29	24-57	45	22	10-37	124	21	14-30
AMI PARKWAY HOSPITAL HOUSTDN TX 77076	TX-50	854	14	9-16	50	32	14-40	27	41	15-49	19	21	5-41	60	22	12-34	23	35	22-60	45	22	8-34	83	24	12-31
AMI RIVERSIDE HOSP INC CORPUS CHRISTI TX 78410	TX-51	672	13	8-16	28	36	10-43	22	50	13-50	15	20	6-48	43	19	14-40	15	40	16-62	21	14	6-42	69	23	13-34
AMI TWELVE OAKS HDSP HOUSTDN TX 77027	TX-52	668	11	9-16	57	19	17-42	34	15	19-51	18	11	6-44	30	13	10-40	22	55	23-63	11	18	3-50	37	27	8-34
AMI WESTBURY HDSPITAL HOUSTON TX 77035	TX-53	246	17	7-17	10	30	13-67	7	29	8-68	10	30	4-53	11	27	7-55	8	50	14-74	6	17	1-63	23	22	8-41
ANDERSDN CO MEMDRIAL HDSP PALESTINE TX 75801	TX-54 *	1046	14	8-15	65	26	13-37	34	35	14-43	16	25	3-41	50	30	14-38	49	47	27-55	34	24	6-35	94	21	12-30
ANGELO COMMUNITY HDSP SAN ANGELO TX 76904	TX-55 *	750	12	8-16	74	30	15-38	26	23	14-48	17	6	5-43	21	29	13-51	21	38	24-64	4	25	0-78	66	18	11-31
ANGLETDN-DANBURY GENERAL H ANGLETDN TX 77515	TX-56	389	16	9-18	9	22	8-63	19	37	12-52	10	10	3-51	26	23	11-44	15	13	17-63	16	13	5-45	43	33	10-35
ANSON GENERAL HDSP ANSON TX 79501	TX-57 *	252	15	11-22	4	75	5-79	28	39	17-51	9	22	7-62	17	47	9-49	16	19	21-67	1	0	0-99	28	7	8-38
ARCHER CO HDSP ARCHER CITY TX 76351	TX-58 *	50	10	7-27	4	50	7-82	1	100	0-97	1	100	0-98	5	20	3-69	4	0	7-82	.	.		4	0	3-76
ARLINGTON MEMDRIAL HDSP ARLINGTDN TX 76012	TX-59 *	2064	11	9-15	138	27	20-39	51	29	18-43	57	16	7-29	96	17	16-33	74	32	28-52	51	27	9-34	119	21	13-30
ATLANTA MEMORIAL HOSPITAL ATLANTA TX 75551	TX-60 *	379	13	10-19	11	55	16-69	18	33	14-55	.	.		36	28	11-39	16	31	20-65	5	0	3-70	67	21	12-32
BALLINGER MEM HOSP INC BALLINGER TX 76821	TX-61 *	181	15	11-24	3	100	6-86	11	45	10-60	6	50	5-69	14	36	9-53	7	29	14-76	11	0	5-53	24	21	15-51
BAPTIST HDSP OF SOUTHEAST BEAUMDNT TX 77701	TX-62	1803	13	10-16	100	23	18-38	65	26	18-41	31	13	11-42	116	26	15-31	61	28	26-51	57	21	11-36	147	27	13-28
BAPTIST HDSPITAL WINNIE WINNIE TX 77665	TX-63 *	149	8	6-18	1	100	2-98	5	20	4-71	5	0	1-68	17	12	7-46	4	25	7-82	3	0	0-85	26	19	8-39
BAPTIST MEMDRIAL HDSP SYST SAN ANTONIO TX 78286	TX-64	7086	12	9-16	493	21	17-31	266	29	23-36	156	17	12-29	446	15	18-28	205	43	30-46	207	21	12-29	569	21	16-27

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALICE PHYSICIANS & SURGEON ALICE TX 78332	16	31	11-58	5	0	7-76	14	0	2-40	.	.		77	6	3-16	37	8	2-22	3	0	0-100	79	0	2-13	7	14	0-97
ALL SAINTS EPISCOPAL HOSP FORT WORTH TX 76104	30	20	9-46	25	28	19-58	151	7	4-15	48	0	0-30	387	4	3-8	151	1	1-11	40	3	0-55	236	4	2-8	307	1	1-5
AMI ALVIN COMMUNITY HOSPIT ALVIN TX 77511	3	67	5-87	13	46	15-65	15	13	2-37	.	.		45	9	1-17	15	7	0-37	2	0	0-100	30	3	1-21	19	5	0-35
AMI BELLAIRE HOSPITAL HOUSTON TX 77081	12	67	13-66	9	67	14-72	18	6	2-35	.	.		48	8	1-17	34	6	1-22	.	.		27	4	1-23	23	4	0-29
AMI COASTAL BEND HOSPITAL ARANSAS PASS TX 78336	6	0	2-67	10	30	14-69	22	5	2-31	2	0	0-100	55	2	2-16	17	6	0-34	5	0	0-100	89	4	2-12	18	6	0-35
AMI DENTON REGIONAL MEDICA DENTON TX 76201	12	17	7-58	13	54	15-65	27	0	3-28	.	.		115	3	2-11	63	6	1-15	10	0	0-100	96	5	2-12	78	3	0-10
AMI FORT BEND COMMUNITY HO MISSOURI CITY TEXAS 77459	1	0	3-99	6	50	10-76	5	0	0-69	.	.		26	19	1-25	8	0	0-59	.	.		14	7	0-37	22	0	0-43
AMI HEIGHTS HOSPITAL HOUSTON TX 77008	6	50	6-72	20	40	19-61	18	17	2-34	.	.		143	6	2-11	69	3	1-15	17	6	0-74	112	4	2-11	61	2	0-12
AMI KATY COMMUNITY HOSP KATY TX 77540	7	14	8-71	15	53	19-67	11	9	1-44	.	.		44	5	1-17	22	5	2-30	.	.		36	3	1-19	12	0	0-61
AMI MEDICAL ARTS HOSPITAL DALLAS TX 75235	.	.		1	0	1-97	.			.	.		7	0	1-57	.	.		2	0	0-100	7	0	0-67	47	0	0-16
AMI PARK PLAZA HOSPITAL HOUSTON TX 77004	18	17	8-51	23	39	20-60	33	0	3-26	11	0	0-89	196	4	3-10	101	7	2-14	36	0	0-56	114	2	2-11	168	2	0-6
AMI PARKWAY HOSPITAL HOUSTON TX 77076	11	27	5-57	9	78	10-66	19	11	3-35	3	0	0-100	85	2	1-12	69	6	1-15	12	17	0-99	72	1	1-12	41	0	0-17
AMI RIVERSIDE HOSP INC CORPUS CHRISTI TX 78410	10	20	9-64	1	0	0-97	23	4	1-28	1	0	0-100	116	8	2-11	32	3	1-22	10	0	0-92	33	3	1-20	26	0	0-33
AMI TWELVE OAKS HOSP HOUSTON TX 77027	9	44	13-72	3	0	4-85	35	6	2-23	24	0	0-88	72	1	1-13	30	10	1-23	5	0	0-100	44	5	1-18	44	2	0-15
AMI WESTBURY HOSPITAL HOUSTON TX 77035	1	100	0-99	3	100	9-91	5	0	0-70	.	.		27	7	0-23	14	29	1-39	2	0	0-100	36	3	1-19	16	6	0-70
ANDERSON CO MEMORIAL HOSP PALESTINE TX 75801	11	9	3-54	16	0	15-61	42	14	2-22	1	0	0-100	124	6	2-12	106	9	2-13	14	0	0-82	66	2	1-13	76	1	0-10
ANGELO COMMUNITY HOSP SAN ANGELO TX 76904	10	20	4-57	3	33	5-86	27	7	4-31	7	0	0-100	73	12	2-14	72	0	0-16	12	0	0-96	65	3	2-14	42	2	0-20
ANGLETON-DANBURY GENERAL H ANGLETON TX 77515	6	50	5-71	10	60	13-69	7	14	2-58	3	0	0-100	65	5	1-14	25	12	1-26	3	0	0-100	40	8	1-18	7	0	0-96
ANSON GENERAL HOSP ANSON TX 79501	4	25	7-82	2	50	10-98	5	0	1-68	.	.		24	4	1-25	4	0	0-82	1	0	0-100	56	4	2-17	12	0	0-48
ARCHER CO HOSP ARCHER CITY TX 76351	1	0	0-98	.	.		.	.		.	.		9	0	0-55	3	0	0-99	.			3	0	0-92	.	.	
ARLINGTON MEMORIAL HOSP ARLINGTON TX 76012	18	22	5-48	25	32	19-58	78	6	4-19	8	0	0-99	208	4	2-9	95	6	2-14	18	0	0-84	243	4	3-9	153	2	0-6
ATLANTA MEMORIAL HOSPITAL ATLANTA TX 75551	7	29	4-65	4	0	3-77	.			.			26	8	0-24	21	10	2-32				36	3	1-19	16	0	0-55
BALLINGER MEM HOSP INC BALLINGER TX 76821	9	22	10-69	1	0	0-97	.	.		.	.		25	0	2-27	5	0	1-68	.	.		10	0	0-49	8	0	0-70
BAPTIST HOSP OF SOUTHEAST BEAUMONT TX 77701	29	17	13-51	22	32	18-58	52	10	3-21	10	0	0-96	191	7	3-11	65	14	2-17	3	0	0-100	188	4	3-10	52	6	0-13
BAPTIST HOSPITAL WINNIE WINNIE TX 77665	3	33	4-85	.	.		1	0	0-100				19	0	0-32	4	0	1-74	1	0	0-100	16	0	0-34	13	0	0-80
BAPTIST MEMORIAL HOSP SYST SAN ANTONIO TX 78286	72	21	13-43	125	39	29-51	219	10	4-14	99	0	0-11	769	4	3-8	374	7	3-11	66	0	0-13	610	6	3-7	363	2	0-4

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BASTROP COMMUNITY HOSPITAL BASTROP TX 78602	TX-65 *	203	16	8-20	6	50	5-69	3	33	3-82	1	100	0-97	13	31	8-52	6	83	13-79	8	13	3-57	40	18	11-37
BAYLOR MEDICAL CENTER AT E ENNIS TX 75119	TX-66	432	19	10-19	27	26	11-45	20	35	14-54	10	20	4-54	30	23	11-42	30	50	20-54	11	45	6-55	52	25	11-34
BAYLOR MEDICAL CENTER AT G GILMER TX 75644	TX-67	452	16	10-19	26	23	10-44	31	32	16-48	11	9	1-47	21	29	13-50	19	32	22-64	6	17	4-67	57	28	14-37
BAYLOR MEDICAL CENTER AT G GRAPEVINE TX 76051	TX-68	272	20	8-18	13	31	6-51	10	40	10-63	6	17	2-63	18	44	9-48	14	50	14-61	7	14	1-59	32	34	9-37
BAYLOR MEDICAL CENTER OF W WAXAHACHIE TX 75165	TX-69	640	19	9-17	51	31	11-36	18	61	16-58	12	25	3-48	31	35	11-41	33	67	24-57	20	25	12-52	59	31	11-33
BAYLOR UNIVERSITY MEDICAL DALLAS TX 75246	TX-70	6334	11	8-15	701	20	18-31	214	34	20-34	104	13	11-29	233	17	16-28	243	34	31-46	92	22	12-33	326	19	14-26
BAYSIDE COMMUNITY HOSPITAL ANAHUAC TX 77514	TX-71 *	101	17	9-25	3	100	10-91	1	0	1-97	5	0	1-68	9	22	7-61	9	56	15-72	3	0	0-84	15	27	9-51
BEAUMONT MEDICAL SURGICAL BEAUMONT TX 77706	TX-72	1448	12	9-15	95	22	14-35	49	16	17-43	50	16	10-35	77	26	16-35	27	59	27-64	44	18	7-33	134	22	15-31
BEEVILLE MEMORIAL HOSPITAL BEEVILLE TX 78102	TX-73 *	409	15	9-18	22	68	14-53	10	30	8-60	15	20	7-50	27	15	11-42	17	35	17-60	19	26	5-42	56	18	11-33
BELLVILLE GENERAL HOSP BELLVILLE TX 77418	TX-74	393	17	9-18	21	29	10-48	11	9	8-57	9	33	4-56	16	50	9-50	29	31	23-58	8	50	3-58	51	33	9-31
BELTWAY COMMUNITY HOSP PASADENA TX 77503	TX-75	200	13	7-18	8	38	5-60	9	33	5-58	2	0	0-91	21	14	9-45	10	60	13-67	9	0	3-56	18	17	5-40
BETHANIA REGIONAL HEALTH C WICHITA FALLS TX 76301	TX-76 *	2144	12	8-15	142	22	15-33	67	25	18-40	52	15	9-33	107	27	15-32	90	40	27-49	41	22	11-40	166	22	13-28
BEXAR COUNTY HOSP DIST MED SAN ANTONIO TX 78284	TX-77	1088	12	7-14	89	18	16-37	35	40	15-45	24	4	5-36	48	19	11-34	30	47	21-55	29	21	6-37	66	20	12-33
BLACKWELL HOSP S EASTLAND GORMAN TX 76454	TX-78 *	94	20	7-22	1	100	0-97	.	.		2	0	0-94	6	50	4-67	6	67	15-81	4	0	2-75	13	46	9-56
BOHNE MEM HOSP BRENHAM TX 77833	TX-79 *	372	15	7-16	33	15	9-39	12	50	8-55	11	36	3-49	19	32	9-46	8	50	14-74	8	0	2-57	34	26	9-36
BOWIE MEM HOSP BOWIE TX 76230	TX-80 *	471	19	11-20	38	39	16-47	22	41	14-52	6	50	3-65	35	29	11-40	27	59	23-59	10	10	3-53	45	22	12-37
BRACKENRIDGE HOSP AUSTIN TX 78701	TX-81 *	1714	15	9-16	113	24	15-35	53	36	16-40	33	30	6-33	85	26	12-30	73	41	26-49	73	25	10-33	133	28	13-28
BRAZOS VALLEY HOSP SEALEY TX 77474	TX-82 *	121	23	8-22	5	40	2-68	10	60	10-63	1	0	0-99	12	50	7-54	4	25	5-80	5	20	3-70	9	44	5-57
BRAZOSPORT MEM HOSP LAKE JACKSON TX 77566	TX-83 *	785	14	8-16	50	34	14-40	30	27	14-46	22	9	5-38	53	28	13-37	35	37	21-53	22	27	5-39	73	27	9-28
BREWSTER MEMORIAL HOSPITAL ALPINE TX 79830	TX-84 *	177	23	10-23	5	80	9-79	11	55	9-59	7	43	3-60	9	67	6-60	11	27	15-68	7	14	1-59	29	24	11-43
BRIDGEPORT HOSPITAL BRIDGEPORT TX 76026	TX-85 *	244	16	8-18	12	58	13-63	8	25	9-67	9	11	1-52	10	50	8-59	9	44	12-68	12	17	3-48	28	18	7-37
BROOKS COUNTY HOSPITAL FALFURRIAS TEXAS 78355	TX-86 *	208	18	10-21	7	100	18-81	5	40	7-75	4	0	0-76	15	13	6-47	12	33	18-69	26	27	7-40	27	22	10-41
BROWNFIELD REGIONAL MEDICA BROWNFIELD TX 79316	TX-87 *	307	16	9-18	15	60	13-58	8	38	6-63	14	14	3-44	16	44	8-49	8	50	14-73	5	0	1-68	59	14	9-30
BROWNSVILLE MEDICAL CENTER BROWNSVILLE TX 78520	TX-88	1016	15	9-16	56	32	14-39	32	44	15-46	22	32	10-46	57	18	14-37	33	30	23-56	46	17	8-34	97	27	12-30
BROWNWOOD REGIONAL HOSPITA BROWNWOOD TX 76801	TX-89 *	1492	11	9-16	109	27	16-35	77	22	18-39	27	4	6-36	82	21	15-35	59	42	28-54	72	7	7-28	122	16	12-28
BUNA MEDICAL CTR HOSPITAL BUNA TX 77612	TX-90 *	134	10	10-24	2	50	7-95	5	20	9-79	1	0	0-97	10	30	9-62	2	50	3-90	6	0	4-67	25	16	13-47

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Oisease			Sepsis			Severe Trauma			Ophthalmology			GI Oisease			Urology			Gynecology			Low Risk Heart Oisease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BASTROP COMMUNITY HOSPITAL BASTROP TX 78602	5	20	5-75	2	50	3-91	2	0	0-95	.	.		20	0	1-29	12	17	0-46	1	0	0-100	15	0	1-35	5	0	0-99
BAYLOR MEOICAL CENTER AT E ENNIS TX 75119	6	33	5-71	7	43	5-66	17	6	2-36	.	.		62	5	2-16	22	23	1-29	4	25	0-100	40	0	1-18	16	0	0-66
BAYLOR MEOICAL CENTER AT G GILMER TX 75644	6	33	3-68	9	33	12-69	1	0	0-99	.	.		43	7	1-18	46	2	1-19	1	0	0-100	54	9	1-15	4	0	0-96
BAYLOR MEOICAL CENTER AT G GRAPEVINE TX 76051	8	0	2-60	6	33	12-78	13	23	1-41	.	.		31	19	1-21	12	0	0-44	.	.		26	8	1-23	7	0	0-97
BAYLOR MEOICAL CENTER OF W WAXAHACHIE TX 75165	11	0	3-55	9	33	11-69	35	6	2-22	1	0	0-100	82	4	2-13	48	6	1-18	7	0	0-100	37	8	1-20	24	4	0-46
BAYLOR UNIVERSITY MEOICAL OALLAS TX 75246	57	25	14-45	46	30	23-54	168	8	4-15	89	0	0-15	503	6	4-9	313	3	1-9	60	2	0-39	781	8	3-7	438	1	0-4
BAYSIOE COMMUNITY HOSPITAL ANAHUAC TX 77514	.	.		2	50	2-90	.	.		.	.		10	0	0-52	4	0	0-80	.	.		7	0	1-57	.	.	
BEAUMONT MEOICAL SURGICAL BEAUMONT TX 77706	32	31	12-49	19	42	16-59	29	7	3-27	30	3	0-72	173	3	2-9	143	3	1-11	26	0	0-60	98	7	2-12	36	0	0-24
BEEVILLE MEMORIAL HOSPITAL BEEVILLE TX 78102	8	25	4-62	3	33	4-85	1	100	0-99	.	.		51	6	1-16	17	12	2-36	1	0	0-100	39	3	1-18	12	0	0-55
BELLVILLE GENERAL HOSP BELLVILLE TX 77418	5	0	6-76	3	67	5-86	15	7	1-37	10	0	0-100	48	6	2-17	31	6	1-23	3	0	0-100	20	0	0-28	13	8	0-72
BELTWAY COMMUNITY HOSP PASAOENA TX 77503	4	50	2-76	3	33	7-88	4	0	0-81	.	.		19	5	0-30	9	0	0-54	4	0	0-100	20	5	0-29	13	0	0-82
BETHANIA REGIONAL HEALTH C WICHITA FALLS TX 76301	20	15	10-53	15	33	18-66	84	10	4-18	5	20	0-96	182	4	2-9	129	5	1-12	35	0	0-91	288	.6	3-9	141	1	0-6
BEXAR COUNTY HOSP OIST MEO SAN ANTONIO TX 78284	22	27	3-43	10	50	14-69	25	28	2-28	4	0	0-100	77	4	2-13	49	8	1-17	10	0	0-100	74	12	2-13	59	0	0-13
BLACKWELL HOSP S EASTLANO GORMAN TX 76454	.	.		1	100	1-97	.	.		.	.		6	17	0-73	2	0	0-97	.	.		21	10	1-27	3	0	0-100
BOHNE MEM HOSP BRENHAM TX 77833	2	50	3-92	3	100	4-84	8	25	2-54	1	0	0-100	36	6	1-20	42	7	1-19	7	0	0-100	12	0	1-41	22	5	0-40
BOWIE MEM HOSP BOWIE TX 76230	11	36	14-69	3	33	4-84	2	0	1-89	.	.		62	10	3-17	23	0	1-27	6	17	0-70	72	6	1-12	13	0	0-59
BRACKENRIOGE HOSP AUSTIN TX 78701	46	13	7-39	23	43	20-60	66	11	4-19	5	0	0-100	130	8	2-12	93	1	2-14	5	0	0-100	137	10	2-10	105	2	0-8
BRAZOS VALLEY HOSP SEALEY TX 77474	1	0	0-97	.	.		3	33	1-81	.	.		15	7	1-36	2	0	0-92	1	0	0-100	7	14	1-57	4	25	0-79
BRAZOSPORT MEM HOSP LAKE JACKSON TX 77566	10	40	8-63	12	67	19-71	32	9	2-24	1	0	0-100	86	2	1-11	47	4	0-18	7	0	0-100	34	0	0-19	45	0	0-15
BREWSTER MEMORIAL HOSPITAL ALPINE TX 79830	1	100	0-97	5	20	9-80	11	27	1-44	.	.		26	4	1-24	5	0	1-68	1	0	0-100	10	10	0-48	7	0	0-97
BRIOGEPORT HOSPITAL BRIOGEPORT TX 76026	7	0	5-67	1	0	0-97	10	0	1-47	.	.		29	7	1-22	11	9	0-47	3	0	0-100	26	15	1-24	8	0	0-96
BROOKS COUNTY HOSPITAL FALFURRIAS TEXAS 78355	5	20	2-71	.	.		2	0	0-91	.	.		28	0	1-22	4	25	0-87	1	0	0-100	21	14	1-28	4	0	0-100
BROWNFIELO REGIONAL MEOICA BROWNFIELO TX 79316	7	14	9-72	3	67	4-85	4	0	0-82	1	0	0-100	41	5	2-19	10	20	0-48	2	0	0-100	28	4	1-22	11	0	0-65
BROWNSVILLE MEOICAL CENTER BROWNSVILLE TX 78520	16	25	9-56	11	27	15-68	28	7	2-26	6	0	0-100	118	7	3-12	68	9	1-15	10	0	0-75	70	4	1-13	55	0	0-13
BROWNWOOO REGIONAL HOSPITA BROWNWOOO TX 76801	11	36	6-58	22	41	19-60	66	9	3-19	7	0	0-100	189	3	2-9	87	1	1-13	28	0	0-56	78	5	2-13	81	1	0-9
BUNA MEOICAL CTR HOSPITAL BUNA TX 77612	.	.		1	0	1-97	.	.		.	.		4	25	0-84	8	0	0-55	.	.		18	0	1-31	7	0	1-57

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BURLESON COUNTY HOSP CALOWELL TX 77836	TX-91	201	14	10-21	9	0	4-56	4	50	4-78	4	50	1-74	18	22	10-48	11	27	13-65	15	7	4-45	28	14	10-41
CAMPBELL MEM HOSP WEATHERFORD TX 76086	TX-92	564	14	10-18	17	6	6-45	22	36	14-51	10	10	4-54	26	35	11-44	38	29	22-53	13	38	7-53	108	17	12-29
CAPROCK HOSP DISTRICT FLOYDADA TX 79234	TX-93 *	146	14	9-22	4	25	3-76	9	56	14-70	4	25	2-75	7	14	4-63	8	50	15-74	4	50	4-78	17	18	8-48
CENTRAL PLAINS REGIONAL HO PLAINVIEW TX 79072	TX-94 *	728	15	8-16	41	29	11-39	29	45	16-49	11	18	8-58	32	13	10-38	29	38	24-60	18	11	5-43	79	24	9-28
CENTRAL TEXAS MEDICAL CENT HEARNE TX 77859	TX-95 *	243	19	10-21	9	78	8-63	11	27	10-61	3	0	0-82	32	13	10-39	18	44	20-63	7	0	1-59	24	25	7-39
CHARLTON METHODIST HOSPITA DALLAS TEXAS 75237	TX-96	920	15	9-16	73	18	13-35	42	14	18-45	21	29	10-48	49	31	11-35	37	43	23-54	42	19	7-33	97	31	10-27
CHARTER COMMUNITY HOSPITAL CLEVELAND TX 77327	TX-97	488	15	9-18	20	55	13-53	18	33	12-52	7	29	5-64	28	4	9-39	27	48	22-59	16	44	12-56	51	29	12-35
CHARTER SUBURBAN HOSP MESQUITE TX 75149	TX-98	645	15	9-17	38	34	12-41	19	37	12-51	22	9	5-39	35	23	10-38	27	52	21-57	15	13	3-44	95	26	13-32
CHEROKEE MEDICAL CENTER RUSK TX 75785	TX-99 *	253	20	12-23	8	50	15-75	12	50	13-62	4	25	1-74	20	40	8-44	6	83	18-85	14	0	3-44	45	29	14-40
CHILDRESS GEN HOSP CHILDRESS TX 79201	TX-100*	283	20	10-20	10	50	14-69	15	73	13-58	10	0	4-52	19	26	7-44	13	62	18-67	7	14	2-59	59	24	11-33
CHILDRESS GENERAL HOSP GOLDTHWAITE TX 76844	TX-101*	158	20	12-26	6	33	7-71	8	0	6-62	4	0	1-74	10	40	8-60	18	61	25-68	7	0	1-59	18	33	13-54
CHILLICOTHE HOSPITAL CHILLICOTHE TX 79225	TX-102*	136	19	9-23	4	25	4-77	2	50	1-89	5	20	1-68	5	40	2-69	3	67	4-85	9	0	2-53	27	41	9-41
CITIZENS GEN HOSP GREENVILLE TX 75401	TX-103	1181	15	10-17	75	39	21-45	57	26	15-38	25	8	5-37	88	20	15-33	52	40	26-53	33	9	7-36	131	26	13-28
CITIZENS HOSPITAL OF COMME COMMERCE TX 75428	TX-104*	206	21	10-22	3	67	2-82	6	50	6-69	.	.		17	41	10-50	10	40	14-69	5	20	3-71	39	28	11-38
CITIZENS MEDICAL CENTER VICTORIA TX 77901	TX-105	1443	11	8-15	79	28	17-40	39	31	15-44	24	17	5-37	89	22	15-33	53	38	25-51	39	31	12-41	84	12	12-31
CLAY COUNTY MEMORIAL HOSPI HENRIETTA TX 76365	TX-106	183	19	9-21	6	17	5-69	5	60	6-74	9	22	3-55	8	50	6-62	8	75	19-80	6	17	1-64	29	17	9-40
CLEARVIEW MIDLAND TX 79704	TX-107*	12	0	0-49	.	.			.			.		.	.		.	.		.	.		.	.	
COCHRAN MEMORIAL HOSPITAL MORTON TX 79346	TX-108*	65	8	5-21	1	0	0-99	.	.		1	0	0-97	2	50	1-89	1	100	3-99	2	0	1-89	9	11	4-55
COLLINGSWORTH GENERAL HOSP WELLINGTON TEXAS 79095	TX-109*	140	14	7-19	1	0	0-98	4	25	3-77	6	0	1-63	2	0	1-89	4	100	13-88	8	13	3-58	24	13	9-42
COLONIAL HILLS HOSPITAL SAN ANTONIO TX 78230	TX-110	56	2	1-16	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
COLONIAL HOSPITAL INC TERRELL TX 75160	TX-111	389	18	8-17	12	33	8-55	16	50	14-58	13	38	4-46	23	39	10-44	13	54	18-67	17	29	6-46	33	24	7-35
COLORADO FAYETTE MEDICAL C WEIMAR TX 78962	TX-112	365	15	9-18	20	30	14-55	19	68	14-54	11	9	3-49	21	29	8-44	6	50	16-82	22	23	8-44	43	28	10-36
COLUMBUS COMMUNITY HOSP COLUMBUS TX 78934	TX-113*	178	15	9-21	3	33	7-88	7	43	9-70	4	0	1-74	14	14	5-46	8	38	9-66	7	29	5-64	34	18	10-38
COMANCHE COMMUNITY HOSPITA COMANCHE TX 76442	TX-114*	243	19	9-19	2	100	4-92	14	43	11-56	4	75	5-79	24	46	9-43	9	44	15-72	4	75	6-80	36	17	9-37
COMFORT COMMUNITY HOSPITAL COMFORT TX 78013	TX-115*	12	8	2-44	.	.		1	100	1-97	.	.		.	.		.	.		1	0	0-100	2	0	0-90
COMMUNITY HOSP OF LUBBOCK LUBBOCK TX 79413	TX-116*	257	14	6-15	7	71	3-61	11	45	8-58	7	0	1-59	14	14	6-47	3	33	5-85	9	44	2-53	30	13	6-33

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BURLESON COUNTY HOSP CALDWELL TX 77836	4	0	4-79	10	50	12-66	3	0	0-93	.	.		19	5	0-30	18	11	1-33	.	.		13	15	0-39	10	0	0-74
CAMPBELL MEM HOSP WEATHERFORD TX 76086	6	33	1-66	8	13	11-71	21	0	1-30	.	.		77	9	2-13	21	5	1-29	2	0	0-100	59	10	1-14	11	0	0-62
CAPROCK HOSP DISTRICT FLDYDADA TX 79234	.	.		.	.		1	0	0-97	.	.		13	0	0-40	6	0	2-63	1	0	0-100	21	0	0-27	10	0	0-91
CENTRAL PLAINS REGIONAL HO PLAINVIEW TX 79072	4	50	6-81	5	40	10-81	38	13	3-23	2	0	0-100	111	10	2-12	49	2	1-17	9	0	0-100	35	11	1-20	34	6	0-26
CENTRAL TEXAS MEDICAL CENT HEARNE TX 77859	4	75	2-76	6	50	13-80	9	0	0-51	.	.		16	6	1-35	18	6	1-33	2	0	0-100	21	10	1-27	11	0	0-84
CHARLTON METHDDIST HOSPITA DALLAS TEXAS 75237	12	25	4-54	11	64	12-64	47	4	2-19	1	0	0-100	106	5	2-11	52	6	1-17	14	0	0-83	90	6	2-12	20	0	0-51
CHARTER COMMUNITY HOSPITAL CLEVELAND TX 77327	5	20	2-71	4	25	7-82	16	6	2-37	.	.		63	5	1-14	39	8	2-22	2	0	0-100	57	7	1-15	10	0	0-52
CHARTER SUBURBAN HOSP MESQUITE TX 75149	7	14	4-65	3	67	4-85	20	10	2-32	5	0	0-100	68	3	2-15	42	7	1-20	4	0	0-100	60	3	1-13	26	0	0-40
CHEROKEE MEDICAL CENTER RUSK TX 75785	15	40	10-58	9	11	16-74	2	0	0-90	.	.		22	5	1-27	3	0	0-90	.	.		27	7	1-23	4	0	0-99
CHILDRESS GEN HOSP CHILDRESS TX 79201	7	14	3-64	1	100	1-97	1	0	0-99	.	.		36	3	0-18	6	0	0-74	7	0	0-100	18	0	1-31	7	14	0-62
CHILDRESS GENERAL HOSP GOLDTHWAITE TX 76844	5	60	5-75	2	0	6-94	4	0	0-74	.	.		19	11	1-30	15	0	1-37	2	0	0-99	12	17	1-41	1	0	0-100
CHILLICOTHE HOSPITAL CHILLICOTHE TX 79225	5	40	4-74	11	18	22-76	1	0	0-98	1	0	0-100	5	0	0-91	2	0	0-96	.	.		12	8	1-41	6	17	0-94
CITIZENS GEN HDSP GREENVILLE TX 75401	17	41	6-50	9	33	15-73	69	9	3-17	2	0	0-100	110	6	2-12	69	6	1-15	7	0	0-100	102	3	2-11	62	2	0-15
CITIZENS HOSPITAL OF COMME COMMERCE TX 75428	1	0	0-97	9	44	17-76	3	0	0-89	.	.		15	0	0-36	1	100	0-100	.	.		10	10	0-48	2	0	0-100
CITIZENS MEDICAL CENTER VICTORIA TX 77901	7	43	6-69	5	0	9-79	27	22	4-30	2	0	0-100	148	5	3-11	77	1	1-14	6	0	0-100	184	8	2-9	81	0	0-9
CLAY COUNTY MEMORIAL HOSPI HENRIETTA TX 76365	8	38	6-65	2	50	6-95	5	0	0-77	.	.		19	0	0-30	14	7	0-39	2	0	0-100	16	13	1-34	2	0	0-100
CLEARVIEW MIDLAND TX 79704	.	.			.		.	.			.		.	.			.		.	.		.	.		.	.	
COCHRAN MEMORIAL HOSPITAL MORTON TX 79346	1	0	1-97	.	.		.	.		.	.		14	0	1-37	2	50	0-98	.	.		7	0	0-64	1	0	0-100
COLLINGSWORTH GENERAL HDSP WELLINGTON TEXAS 79095	2	100	1-90	1	100	2-98	.	.		.	.		18	6	1-31	6	0	1-62	1	0	0-100	18	11	1-31	2	0	0-100
COLONIAL HILLS HOSPITAL SAN ANTONIO TX 78230	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
COLONIAL HOSPITAL INC TERRELL TX 75160	9	44	8-65	.	.		13	8	2-41	.	.		56	16	3-19	19	5	1-31	5	0	0-100	36	0	1-18	15	0	0-75
COLORADO FAYETTE MEDICAL C WEIMAR TX 78962	2	50	4-92	6	67	20-87	11	0	1-44		.		43	2	1-17	15	0	0-41	6	0	0-100	28	0	1-22	12	0	0-45
COLUMBUS COMMUNITY HOSP COLUMBUS TX 78934	1	0	0-98	6	33	9-75	.	.		9	0	0-100	20	10	1-29	9	11	0-53	1	0	0-100	14	0	0-40	3	0	0-100
COMANCHE COMMUNITY HOSPITA COMANCHE TX 76442	5	60	5-75	.	.		10	0	0-51				21	5	1-28	9	0	0-54	.	.		21	5	1-27	15	0	0-54
COMFORT COMMUNITY HOSPITAL COMFORT TX 78013	1	0	1-97	.	.		.	.		.	.		1	0	0-100	1	0	0-100	.	.		.	.		.	.	
COMMUNITY HOSP OF LUBBOCK LUBBOCK TX 79413	1	0	0-99	3	33	4-84	4	0	0-81		.		27	7	0-23	15	7	0-39	5	0	0-100	24	4	1-25	18	0	0-54

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
COMMUNITY HOSPITAL OF TYLE TYLER TX 75702	TX-117*	239	12	9-19	8	25	7-65	6	50	10-75	5	20	2-69	18	11	10-50	10	30	18-73	17	18	6-45	30	30	9-39
COMMUNITY MEM HOSP GRAPELAND TX 75844	TX-118*	58	28	9-29	1	100	0-97	6	50	8-72	4	25	0-75	6	33	4-67	7	57	10-72	.	.		13	15	5-48
CONCHO COUNTY HOSP DISTRIC EDEN TX 76837	TX-119	107	11	8-22	2	100	7-95	5	40	4-72	4	25	1-74	13	0	5-48	5	40	10-80	.	.		21	0	5-39
CONTINENTAL HOSPITAL BOULE FORT WORTH TX 76107	TX-120*	32	0	2-24		.		.	.		1	0	0-100	2	0	0-90	.	.		2	0	0-90	4	0	1-74
CONTINENTAL HOSPITAL NORTH FORT WORTH TX 76106	TX-121*	250	20	9-19	3	0	1-81	5	20	4-71	5	80	6-76	19	21	10-48	11	45	18-71	4	0	0-76	36	22	11-39
CONTINENTAL HOSPITAL SUBUR FORT WORTH TX 76108	TX-122*	138	18	6-18	2	0	0-91	1	0	0-97	.	.		8	0	6-62	2	0	3-91	5	60	2-69	24	25	6-38
COOK MEMORIAL HOSP LEVELLAND TX 79336	TX-123*	414	13	8-17	20	50	14-54	11	18	10-60	18	17	4-41	15	20	9-52	9	56	17-74	7	0	1-59	62	24	12-34
COON MEM HOSPITAL AND HOME DALHART TX 79022	TX-124*	151	14	8-21	4	25	5-79	4	25	4-78	5	40	3-70	17	47	10-50	5	60	11-81	6	0	4-67	26	12	6-37
CORPUS CHRISTI OSTEOPATHIC CORPUS CHRISTI TX 78415	TX-125	316	11	6-15	10	20	4-53	7	71	8-68	11	18	3-50	17	18	8-47	12	33	17-68	10	0	2-50	25	24	7-38
CORYELL MEM HOSP GATESVILLE TX 76528	TX-126	379	18	11-20	20	50	17-58	21	33	14-52	9	0	3-54	21	48	11-48	22	36	22-62	10	10	3-52	53	21	11-34
COZBY-GERMANY HOSP GRAND SALINE TX 75140	TX-127*	256	16	9-19	10	30	8-60	8	25	7-64	5	0	4-72	23	39	9-42	9	67	17-74	11	9	4-52	38	29	11-38
CRANE MEM HOSP CRANE TX 79731	TX-128*	39	10	5-28	1	0	0-98	4	50	3-76	1	0	0-99	1	0	0-99	3	67	9-90	.	.		13	0	2-42
CROSBYTON CLINIC HOSP CROSBYTON TX 79322	TX-129*	273	14	10-21	6	83	16-82	10	20	8-59	3	67	6-87	30	23	13-44	11	55	18-71	16	0	2-41	53	17	10-33
CUERO COMMUNITY HOSP CUERO TX 77954	TX-130*	427	17	11-20	19	42	14-54	24	46	15-52	10	0	2-50	39	23	13-40	25	36	21-58	17	6	4-42	73	22	12-32
CULBERSON CO HOSP VAN HORN TX 79855	TX-131*	24	0	2-28	2	0	1-89	1	0	0-97	.	.		.	.		1	0	0-97	.	.		1	0	0-100
CYPRESS FAIRBANKS MEDICAL HOUSTON TX 77065	TX-132*	385	10	7-16	17	47	16-59	11	18	9-58	7	43	3-61	29	28	11-42	13	23	17-66	2	0	0-93	37	14	9-35
D M COGDELL MEM HOSP SNYDER TX 79549	TX-133*	313	16	8-18	4	50	4-77	14	43	14-60	10	20	3-52	20	25	8-44	7	100	13-76	19	26	8-46	46	28	10-35
DALLAS FAMILY HOSP DALLAS TX 75224	TX-134	574	16	8-16	35	23	14-44	19	11	12-51	13	62	5-49	31	26	9-38	15	33	18-64	25	12	6-38	44	36	10-35
DALLAS MED AND SURGICAL HO DALLAS TX 75204	TX-135*	255	9	6-16	26	19	9-43	6	33	5-68	12	8	2-46	13	31	7-51	9	44	15-72	3	33	1-82	23	0	5-37
DALLAS MEMORIAL HOSPITAL DALLAS TX 75206	TX-136*	121	6	6-18	2	0	1-89	2	50	3-91	1	0	0-99	22	5	7-40	2	0	4-92	4	0	1-74	4	0	1-74
DALLAS/FORT WORTH MED CTR-GRAND PRAIRIE TX 75051	TX-137*	632	15	8-16	24	38	12-48	21	19	15-53	9	22	2-52	33	21	8-36	23	35	21-60	16	13	8-51	79	28	12-32
DANFORTH MEM HOSP INC TEXAS CITY TX 77590	TX-138	525	14	9-17	40	20	13-41	23	9	10-45	8	25	2-56	32	28	12-41	21	43	19-59	19	32	9-48	40	30	10-36
DAVID GRANBERRY MEM HOSP A NAPLES TX 75568	TX-139*	168	15	8-20	5	60	7-77	6	17	6-69	2	50	0-92	25	32	11-44	2	0	3-91	10	10	4-54	11	36	7-55
DEAF SMITH GENERAL HOSP HEREFORD TX 79045	TX-140*	349	11	8-17	20	25	11-50	7	29	7-67	5	20	2-68	15	13	9-51	18	44	22-65	5	40	2-69	36	19	9-36
DEATON HOSP GALENA PARK TX 77547	TX-141	74	16	5-21	2	100	4-92	1	0	0-97	1	0	0-99	2	50	0-90	1	0	1-97	4	25	1-75	14	14	5-47
DECATUR COMMUNITY HOSP DECATUR TX 76234	TX-142	278	15	9-19	15	20	9-52	7	43	10-71	4	25	3-76	18	44	8-47	16	44	18-62	21	24	8-45	27	11	6-36

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
COMMUNITY HOSPITAL OF TYLE TYLER TX 75702	4	0	1-76	.	.		1	0	0-100	.	.		18	0	0-33	15	0	2-37	1	0	0-100	17	6	1-32	10	0	0-81
COMMUNITY MEM HOSP GRAPELAND TX 75844	1	0	0-98	.	.		.	.		.	.		3	0	0-100	1	0	0-100	.	.		.	.				
CONCHO COUNTY HOSP DISTRIC EDEN TX 76837	1	100	2-98				1	0	0-99	.	.		9	0	0-63	6	17	2-62	.	.		8	13	0-55	3	0	0-100
CONTINENTAL HOSPITAL BOULE FORT WORTH TX 76107	.	.		1	0	1-97	.	.		.	.		4	0	0-95	1	0	0-100	.	.		3	0	0-97	7	0	0-100
CONTINENTAL HOSPITAL NORTH FORT WORTH TX 76106	3	67	5-86	2	100	7-95	10	20	1-47	.	.		22	5	0-27	23	22	1-28	2	50	0-100	20	10	0-28	10	10	0-60
CONTINENTAL HOSPITAL SUBUR FORT WORTH TX 76108	4	0	3-77	2	0	3-91	3	0	0-91	.	.		17	6	0-34	9	33	1-50	1	0	0-100	5	0	0-79	10	0	0-94
COOK MEMORIAL HOSP LEVELLAND TX 79336	6	17	5-70	7	14	10-73	5	0	0-72	1	0	0-100	70	3	1-13	13	8	0-42	2	0	0-100	40	5	1-19	19	5	0-37
COON MEM HOSPITAL AND HOME DALHART TX 79022	4	25	3-78							.	.		19	0	0-30	11	9	0-46	.	.		11	0	0-48	9	0	0-85
CORPUS CHRISTI OSTEOPATHIC CORPUS CHRISTI TX 78415	4	25	4-79	8	25	7-64	8	13	1-53	.	.		29	10	0-22	10	0	0-55	6	0	0-100	28	0	0-22	20	0	0-44
CORYELL MEM HOSP GATESVILLE TX 76528	4	25	4-79	5	0	4-73	4	25	0-75	.	.		36	3	1-19	22	9	2-30	7	0	0-100	38	11	2-20	8	25	0-54
COZBY-GERMANY HOSP GRAND SALINE TX 75140	3	33	1-82	1	100	2-98	3	0	0-92	.			30	10	0-21	6	0	0-75	.	.		18	0	1-31	9	0	0-55
CRANE MEM HOSP CRANE TX 79731	.	.		.	.		.	.		.	.		4	0	0-94	2	0	0-98	.	.		1	0	0-100	.		
CROSBYTON CLINIC HOSP CROSBYTON TX 79322	11	18	7-60	2	50	3-91	.	.		.	.		26	0	0-24	9	0	1-50	.	.		20	10	1-29	11	0	0-82
CUERO COMMUNITY HOSP CUERO TX 77954	2	50	3-91	3	33	4-84	11	9	0-45	.	.		33	9	1-21	25	4	1-27	6	0	0-100	27	4	1-23	9	0	0-79
CULBERSON CO HOSP VAN HORN TX 79855	2	0	0-90	.	.		.	.		.	.		4	0	0-94	.	.		.	.		4	0	0-89	1	0	0-100
CYPRESS FAIRBANKS MEDICAL HOUSTON TX 77065	7	14	2-63	2	50	5-93	8	13	0-56		.		44	0	1-17	14	0	1-38	1	0	0-100	37	5	0-17	16	0	0-36
D M COGDELL MEM HOSP SNYDER TX 79549	4	25	3-77	7	29	10-72	10	10	1-47	.	.		33	0	0-20	14	7	1-38	1	0	0-100	29	3	1-22	22	5	0-32
DALLAS FAMILY HOSP DALLAS TX 75224	6	33	7-73	7	29	11-74	10	30	2-49	1	0	0-100	64	3	1-13	63	8	2-16	10	10	0-81	36	6	1-19	53	0	0-14
DALLAS MED AND SURGICAL HO DALLAS TX 75204	5	20	1-71	2	0	2-90	.	.		4	0	0-100	62	0	1-13	11	9	0-49	10	0	0-100	7	14	0-65	5	0	0-98
DALLAS MEMORIAL HOSPITAL DALLAS TX 75206	7	29	3-64	2	0	3-91	2	50	0-96	.	.		12	0	0-43	7	0	0-64	.			4	0	0-87	7	0	0-94
DALLAS/FORT WORTH MED CTR-GRAND PRAIRIE TX 75051	6	33	3-68	7	57	12-75	12	8	2-44	5	0	0-99	56	5	1-15	44	11	2-20	3	0	0-100	46	4	1-16	32	0	0-23
DANFORTH MEM HOSP INC TEXAS CITY TX 77590	5	20	4-74	4	50	8-84	6	17	1-62	.	.		65	6	1-14	21	5	0-31	6	0	0-100	56	5	1-14	25	4	0-33
DAVID GRANBERRY MEM HOSP A NAPLES TX 75568	3	33	0-83	4	75	7-82	1	0	0-98		.		19	0	1-30	6	0	0-63	3	0	0-100	9	0	0-55	6	0	0-97
DEAF SMITH GENERAL HOSP HEREFORD TX 79045	1	100	3-99	5	40	12-83	13	23	4-45	.			60	5	2-16	24	4	0-28	5	0	0-100	25	0	1-24	32	0	0-22
DEATON HOSP GALENA PARK TX 77547	1	0	1-97	.	.		.	.		.	.		14	7	0-38	.	.		.	.		13	15	0-40	2	0	0-100
DECATUR COMMUNITY HOSP DECATUR TX 76234	2	100	3-91	1	0	0-97	13	0	1-40	.	.		38	3	1-18	17	12	1-34	2	50	0-99	29	0	1-21	1	0	0-100

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
OELEON HOSPITAL OE LEON TX 76444	TX-143*	375	14	8-17	7	29	5-64	16	25	9-51	11	27	5-53	28	18	11-43	13	77	23-73	5	0	1-69	41	17	10-35
OETAR HOSPITAL INC VICTORIA TX 779D1	TX-144*	1346	12	9-16	147	16	17-35	39	33	14-43	39	21	9-36	49	14	12-36	35	31	24-56	33	30	9-40	114	21	12-29
OIAGNOSTIC CENTER HOSP HOUSTON TX 7703D	TX-145*	1281	12	9-16	132	18	17-36	46	33	18-45	34	15	11-41	51	35	13-37	22	36	22-61	28	21	10-43	101	24	13-30
OIMMIT CO MEMORIAL HOSP CARRIZO SPRINGS TX 78834	TX-146*	271	15	9-2D	4	50	2-75	12	42	10-58	9	33	4-57	12	8	7-53	15	27	20-66	29	24	8-40	35	29	13-42
OOCTORS HOSP HOUSTON TX 77076	TX-147*	677	14	8-16	45	44	13-40	14	36	12-58	17	12	3-39	38	24	10-36	21	38	23-63	13	31	5-49	88	18	10-28
OOCTORS HOSPITAL DALLAS TX 75218	TX-148	1660	15	11-18	115	30	17-37	73	30	18-40	41	32	8-34	111	15	16-32	86	34	29-51	37	16	5-32	167	29	14-29
OOCTORS HOSPITAL INC GROVES TX 77619	TX-149*	498	9	7-15	16	13	8-49	19	26	12-51	9	22	2-53	22	32	9-44	17	47	23-67	12	17	2-46	40	15	9-34
DOCTORS HOSPITAL LAREOO LAREDO TX 78041	TX-150*	446	13	8-17	27	30	15-51	10	60	9-61	9	56	5-58	32	38	11-41	15	47	19-65	6	0	2-64	29	17	8-38
OOCTORS MEM HOSP TYLER TX 757D1	TX-151*	355	13	8-17	9	33	14-71	9	11	12-69	6	33	2-63	13	23	7-51	10	5D	18-74	12	42	6-53	54	19	10-33
DOLLY VINSANT MEM HOSP SAN BENITO TX 78586	TX-152*	554	14	8-16	27	26	14-49	34	21	14-44	11	9	4-52	42	21	10-35	8	25	13-72	13	31	9-56	61	34	10-31
DUBLIN MEOICAL CENTER DUBLIN TX 76446	TX-153	201	14	10-22	3	0	4-84	10	20	8-60	5	0	4-72	8	50	7-64	19	32	20-62	5	20	0-70	38	21	11-38
E L GRAHAM MEM HOSP CISCO TX 76437	TX-154*	124	17	9-23	4	10D	9-84	3	0	2-82	2	0	1-89	6	33	3-65	8	50	10-68	4	25	1-74	21	29	6-41
EAGLE LAKE COMMUNITY HOSPI EAGLE LAKE TX 77434	TX-155*	246	14	8-18	4	0	1-74	18	50	14-56	9	33	4-56	7	43	7-67	6	100	14-80	14	36	8-53	37	5	6-30
EASTLAND MEM HOSP EASTLAND TX 76448	TX-156*	258	14	7-17	5	60	9-79	21	38	12-49	4	25	0-77	7	29	5-63	12	42	15-65	3	0	0-83	29	14	8-37
EASTWAY GENERAL HOSPITAL HOUSTON TX 77029	TX-157*	430	14	9-17	28	39	12-45	10	50	8-60	21	19	8-43	32	13	10-39	11	36	13-65	14	7	4-45	53	25	12-35
EOGAR B OAVIS MEM HOSP LULING TX 78648	TX-158*	226	18	9-19	18	44	8-47	15	40	12-57	5	2D	2-68	17	12	7-45	12	67	18-70	7	29	3-62	28	29	7-37
EOINBURG GEN HOSP EOINBURG TX 78539	TX-159*	521	15	8-17	20	25	9-47	23	26	12-47	10	3D	8-60	25	28	9-41	22	55	21-60	14	14	8-53	70	27	13-34
EONA HOSP EONA TX 77957	TX-160*	145	17	10-23	9	44	9-64	4	50	3-77	4	25	3-77	20	25	9-46	3	33	6-86	9	0	3-55	26	31	9-42
ELECTRA MEMORIAL HOSP ELECTRA TX 76360	TX-161*	107	11	8-23	3	0	0-83	6	33	6-7D	5	20	3-71	9	11	7-60	7	57	15-78	2	0	D-90	10	0	6-56
FAIRFIELO MEMORIAL HOSPITA FAIRFIELO TX 7584D	TX-162*	244	13	9-2D	13	46	9-56	4	50	4-77	5	20	1-68	21	5	9-45	16	25	19-64	9	0	2-54	44	14	8-32
FAMILY HOSPITAL CENTER AMARILLO TX 79109	TX-163	338	17	11-20	14	36	8-53	14	36	13-59	6	0	3-65	16	31	9-49	8	63	17-77	37	22	9-38	53	19	12-36
FANNIN CO HOSP BONHAM TX 75418	TX-164	469	15	10-19	19	37	15-57	23	48	14-50	12	33	8-57	39	13	11-38	24	46	26-65	15	7	4-44	58	26	12-34
FAYETTE MEMORIAL HOSP LA GRANGE TX 78945	TX-165*	321	16	11-20	16	50	10-53	17	35	11-52	6	0	1-63	31	29	11-41	9	44	20-78	8	63	13-73	40	10	9-35
FISHER CO HOSP OISTRICT ROTAN TX 79546	TX-166*	161	16	8-20	1	0	0-97	7	57	7-68	3	33	4-84	11	18	6-55	9	56	12-68	10	30	7-59	12	25	7-53
FLOW MEM HOSP DENTON TX 76201	TX-167*	638	15	8-16	24	38	10-45	25	36	14-50	15	20	4-43	30	23	1D-40	28	39	23-59	29	28	6-37	66	23	10-31
FOARD COUNTY HOSPITAL OIST CROWELL TX 79227	TX-168*	50	26	11-35	2	100	7-95	1	100	0-97	.	.		2	0	0-90	14	5D	16-64	1	0	0-100	1D	20	7-57

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
DELEON HOSPITAL DE LEON TX 76444	4	0	7-83	4	0	6-81	14	0	1-38	.	.		37	14	2-21	21	5	2-31	2	0	0-100	26	8	1-24	35	3	0-19
DETAR HOSPITAL INC VICTORIA TX 77901	15	27	4-49	14	57	20-69	29	10	2-25	11	0	0-99	143	1	2-11	101	7	1-12	11	0	0-96	72	6	2-14	100	1	0-8
DIAGNOSTIC CENTER HOSP HOUSTON TX 77030	5	40	2-71	14	29	17-66	14	7	2-39	23	0	0-69	149	2	3-12	72	0	1-14	19	5	0-83	71	7	2-13	70	1	0-10
DIMMIT CO MEMORIAL HOSP CARRIZO SPRINGS TX 78834	3	67	5-87	.	.		.	.		.			43	2	1-17	23	0	0-30	1	0	0-100	7	14	0-61	10	0	0-72
DOCTORS HOSP HOUSTON TX 77076	5	80	6-76	11	36	17-71	7	29	1-57	2	0	0-100	78	3	1-12	55	9	1-17	4	0	0-100	68	1	1-13	27	4	0-30
DOCTORS HOSPITAL DALLAS TX 75218	19	32	13-58	27	30	22-60	98	3	4-16	2	0	0-100	210	6	3-10	74	7	2-16	18	0	0-84	146	5	2-10	69	0	0-11
DOCTORS HOSPITAL INC GROVES TX 77619	3	33	3-84	.	.		8	0	1-53	1	0	0-100	67	4	1-13	33	6	2-24	8	0	0-100	42	2	1-17	38	5	0-17
DOCTORS HOSPITAL LAREDO LAREDO TX 78041	.			7	29	12-75	6	0	1-63	14	0	0-98	41	2	1-17	36	0	1-21	4	0	0-100	44	0	1-17	19	0	0-56
DOCTORS MEM HOSP TYLER TX 75701	3	33	4-85	1	100	2-98	9	22	1-50	.			51	2	1-16	17	12	1-34	4	0	0-97	25	4	1-24	32	0	0-20
DOLLY VINSANT MEM HOSP SAN BENITO TX 78586	7	29	6-69	2	0	3-91	6	0	0-63	.			92	4	1-11	39	15	1-20	7	0	0-100	27	11	0-22	22	0	0-39
DUBLIN MEDICAL CENTER DUBLIN TX 76446	8	25	5-64	.	.		3	0	0-83		.		13	0	0-41	9	22	1-50	3	0	0-100	27	4	1-23	7	0	0-97
E L GRAHAM MEM HOSP CISCO TX 76437	5	0	4-74	2	50	3-91	9	0	1-50		.		9	0	1-49	4	25	0-75	1	0	0-100	16	13	1-35	3	0	0-100
EAGLE LAKE COMMUNITY HOSP EAGLE LAKE TX 77434	4	0	1-76	4	25	4-78	10	0	1-47		.		31	0	0-21	9	0	1-50	3	0	0-100	24	4	1-25	9	0	0-73
EASTLAND MEM HOSP EASTLAND TX 76448	8	0	3-60	1	100	2-98	19	11	1-31		.		33	3	0-20	8	25	1-53	2	50	0-98	23	0	1-26	11	0	0-71
EASTWAY GENERAL HOSPITAL HOUSTON TX 77029	1	0	0-100	8	38	16-77	13	0	1-40		.		58	3	1-14	13	0	0-43	4	0	0-100	25	0	0-24	26	0	0-41
EDGAR B DAVIS MEM HOSP LULING TX 78648	2	0	0-90	.	.		9	11	1-50	.	.		20	0	0-30	14	7	1-38	3	0	0-100	16	0	0-35	8	0	0-77
EDINBURG GEN HOSP EDINBURG TX 78539	8	13	2-60	3	67	4-84	20	10	1-31	1	0	0-100	78	4	1-12	23	4	0-28	5	0	0-100	43	5	1-17	13	0	0-84
EDNA HOSP EDNA TX 77957	4	25	4-78	1	0	1-97	2	0	1-89	.			2	0	0-97	4	0	0-83		.		8	0	0-55	5	0	0-100
ELECTRA MEMORIAL HOSP ELECTRA TX 76360				1	100	1-97	.						13	8	1-39	13	8	2-41				11	0	0-47	2	0	0-100
FAIRFIELD MEMORIAL HOSPITA FAIRFIELD TX 75840	3	67	1-82	7	57	9-71	2	0	0-93		.		33	6	1-20	3	0	0-81	.	.		22	5	0-26	.		
FAMILY HOSPITAL CENTER AMARILLO TX 79109	2	50	1-90	4	25	7-82	3	0	1-81	1	0	0-100	38	8	1-19	26	4	2-28	1	0	0-100	17	6	1-32	11	0	0-71
FANNIN CO HOSP BONHAM TX 75418	7	14	5-67	6	17	9-75	1	0	0-99	.	.		55	2	1-15	25	4	0-26	1	0	0-100	39	3	1-19	14	0	0-66
FAYETTE MEMORIAL HOSP LA GRANGE TX 78945	5	20	4-74	11	64	18-72	9	0	2-51				43	7	1-18	19	0	1-32	3	0	0-100	14	0	0-38	8	0	0-84
FISHER CO HOSP DISTRICT ROTAN TX 79546							2	0	0-98	.			24	8	0-25	5	0	3-69	1	0	0-100	14	7	1-37	2	0	0-100
FLOW MEM HOSP DENTON TX 76201	5	20	2-71	3	0	4-84	30	10	1-24				46	13	1-17	40	13	1-20	4	0	0-100	43	5	1-17	47	0	0-15
FOARD COUNTY HOSPITAL DIST CROWELL TX 79227	2	0	2-90	.	.								3	0	0-98	3	0	0-97		.		3	0	0-94			

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
FRANKLIN CO HOSP MOUNT VERNON TX 75457	TX-169*	198	17	9-21	9	56	12-69	16	44	14-58	4	25	1-74	9	33	6-59	15	33	18-65	7	0	1-59	23	22	7-40
FRIO HOSP PEARSALL TX 78061	TX-170*	193	11	8-20	4	50	3-76	2	50	2-90	9	11	5-58	18	33	9-48	9	44	18-76	9	11	5-59	19	21	7-44
FT WORTH OSTEO MEDCIAL CTR FORT WORTH TX 76107	TX-171	1273	17	9-16	70	30	17-40	36	6	15-45	25	36	8-42	77	21	15-35	36	47	24-56	50	32	10-36	141	28	13-28
GAINESVILLE MEMORIAL HOSP GAINESVILLE TX 76240	TX-172*	595	14	10-18	32	28	13-44	35	29	14-44	15	7	3-41	42	21	11-37	37	41	25-57	29	7	5-36	68	26	12-33
GARLAND COMMUNITY HOSPITAL GARLAND TX 75042	TX-173	338	16	9-18	21	38	17-57	11	27	10-60	12	17	3-47	15	40	6-47	8	63	11-70	5	20	2-70	53	13	12-35
GARZA MEM HOSP POST TX 79356	TX-174*	60	18	7-26	5	80	3-70	1	0	0-97	.	.		2	0	1-89	2	100	5-93	.	.		12	17	5-49
GASTON EPISCOPAL HOSP DALLAS TX 75246	TX-175	678	6	5-13	70	11	14-36	14	7	12-58	14	0	4-46	18	28	9-48	7	43	12-75	12	17	2-47	54	19	10-32
GENERAL HOSP IRAAN TX 79744	TX-176*	21	5	3-33	.	.		.	.		.	.		1	100	0-97	.	.		2	0	0-93	6	0	4-67
GENERAL HOSPITAL OF LAKEWO DALLAS TX 75214	TX-177	233	21	13-25	9	22	13-70	18	22	13-54	8	0	4-60	19	26	8-44	12	42	17-68	5	20	1-68	45	38	15-42
GEORGETOWN HOSPITAL GEORGETOWN TX 78626	TX-178	536	14	8-16	45	27	11-37	21	38	12-49	10	10	1-49	27	15	11-43	14	36	14-61	18	22	5-44	62	16	11-32
GLADEWATER HOSPITAL AUTHOR GLADEWATER TX 75647	TX-179*	285	19	10-20	14	29	11-57	18	44	14-55	9	11	1-51	24	25	9-42	16	56	21-66	5	40	2-69	39	15	9-35
GOLDEN PLAINS COMMUNITY HO BORGER TX 79007	TX-180*	304	17	9-18	19	21	7-44	13	31	9-56	10	20	3-51	19	16	7-44	22	45	20-59	16	31	5-45	29	14	6-35
GOLIAD CO HOSP GOLIAD TX 77963	TX-181*	116	16	10-24	7	43	11-73	3	33	5-86	2	0	1-89	8	13	6-62	5	60	13-84	5	60	3-70	16	25	8-49
GOOD SHEPHERD MEDICAL CENT LONGVIEW TX 75601	TX-182	2025	12	10-16	148	23	18-36	70	39	20-43	35	11	8-36	106	24	15-32	92	39	28-50	63	19	10-34	134	21	14-30
GOODALL - WITCHER HOSPITAL CLIFTON TX 76634	TX-183*	537	15	9-18	54	28	13-38	20	35	13-51	18	22	8-47	32	19	11-40	33	52	24-57	8	13	2-56	36	28	12-40
GRAHAM GENERAL HOSP GRAHAM TX 76046	TX-184	354	20	12-21	12	50	8-56	12	50	12-61	18	22	5-42	13	8	8-54	26	50	24-61	8	25	4-59	72	24	14-34
GRANVILLE C MORTON HOSPITA DALLAS TX 75235	TX-185*	114	18	9-24	24	38	16-54	1	0	1-98	3	33	0-82	1	100	1-97	1	0	1-97	2	0	5-93	2	50	2-89
GUADALUPE VALLEY HOSP SEGUIN TX 78155	TX-186*	803	14	8-16	47	30	12-38	33	48	14-44	21	24	6-41	38	24	13-40	32	50	23-56	9	0	4-56	89	24	12-30
GULF COAST HOSPITAL BAYTOWN TX 77521	TX-187	565	17	8-17	22	32	12-50	44	25	13-39	13	15	4-46	43	40	13-39	18	61	17-59	23	9	5-38	71	20	9-29
GULF COAST MEDICAL CENTER WHARTON TX 77488	TX-188	773	13	9-17	68	24	14-37	22	41	12-49	23	13	4-36	29	28	12-44	32	31	22-55	21	19	11-49	57	23	12-35
HALL CO HOSP MEMPHIS TX 79245	TX-189*	168	20	9-21	7	71	8-70	8	38	7-65	3	0	1-81	8	38	4-58	17	47	21-66	11	18	2-48	19	42	7-44
HALL-BENNETT MEMORIAL HOSP BIG SPRING TX 79721	TX-190*	313	24	11-20	14	36	11-57	20	55	16-55	4	50	1-74	10	40	4-53	28	46	24-60	3	0	2-82	40	33	12-39
HALTOM HOSPITAL FORT WORTH TX 76117	TX-191*	106	16	8-22	5	40	6-75	6	33	8-72	3	0	3-83	9	44	5-57	1	100	3-99	6	0	1-63	14	21	8-52
HAMILTON GENERAL HOSPITAL HAMILTON TX 76531	TX-192*	204	20	9-21	8	50	8-65	4	50	7-81	10	40	4-54	11	18	8-56	13	38	18-67	12	17	6-53	28	32	8-38
HAMILTON HOSPITAL OLNEY TX 76374	TX-193*	257	15	8-18	10	50	9-61	3	67	3-83	9	11	3-54	14	29	10-55	11	27	17-70	6	50	2-64	32	34	11-40
HAMLIN MEM HOSP HAMLIN TX 79520	TX-194*	145	12	8-20	2	0	1-89	9	11	8-62	8	13	2-55	3	0	2-81	11	45	20-73	7	14	4-63	15	27	5-46

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
FRANKLIN CO HOSP MOUNT VERNON TX 75457	5	20	4-73	2	0	4-92	3	0	0-91	.	.		21	0	0-30	8	0	1-53	4	0	0-100	14	0	0-40	7	0	0-95
FRIO HOSP PEARSALL TX 78061	1	100	1-98	1	0	1-97	2	0	0-93	.	.		22	0	1-27	9	0	1-50	1	0	0-100	28	0	1-22	4	0	0-95
FT WORTH OSTEO MEDCIAL CTR FORT WORTH TX 76107	18	28	8-52	17	29	18-63	42	10	3-23	6	0	0-100	89	11	2-14	73	18	4-19	10	0	0-99	104	5	2-11	101	1	0-8
GAINESVILLE MEMORIAL HOSP GAINESVILLE TX 76240	9	0	4-60	4	0	8-83	22	5	2-30	1	0	0-100	56	13	2-17	42	2	1-19	5	0	0-100	60	7	2-15	27	0	0-43
GARLAND COMMUNITY HOSPITAL GARLAND TX 75042	4	0	2-76	10	50	10-64	23	9	2-29	.	.		19	11	1-31	19	5	1-31	1	0	0-100	23	0	0-26	20	0	0-53
GARZA MEM HOSP POST TX 79356	1	0	0-97	5	60	9-79	.	.		.	.		5	0	0-82	1	0	0-99	.	.		3	0	0-92	2	0	0-100
GASTON EPISCOPAL HOSP DALLAS TX 75246	2	50	2-90	2	50	2-90	13	8	1-40	6	0	0-100	84	4	1-12	35	3	0-22	20	0	0-97	17	18	0-32	140	0	0-7
GENERAL HOSP IRAAN TX 79744	.	.		.	.		.	.		.	.		2	0	0-100	1	0	0-100	.	.		2	0	0-99	.	.	
GENERAL HOSPITAL OF LAKEWO DALLAS TX 75214	3	33	3-84	11	45	16-70	9	44	1-50	1	0	0-100	18	0	0-32	6	17	1-63	1	0	0-100	13	0	0-40	15	0	0-60
GEORGETOWN HOSPITAL GEORGETOWN TX 78626	5	40	4-73	15	47	12-58	32	13	3-26	5	0	0-100	61	7	1-14	51	6	1-17	4	0	0-100	39	0	1-18	29	0	0-25
GLADEWATER HOSPITAL AUTHOR GLADEWATER TX 75647	8	50	13-75	.	.		3	0	0-85	1	0	0-100	39	3	1-19	13	23	1-40	1	0	0-100	20	5	0-28	11	0	0-72
GOLDEN PLAINS COMMUNITY HO BORGER TX 79007	4	50	10-87	3	67	6-88	.	.		.	.		27	7	1-23	29	0	0-25	6	0	0-100	30	7	1-21	6	0	0-99
GOLIAD CO HOSP GOLIAD TX 77963	7	0	6-68	3	33	5-86	.	.		.	.		14	0	0-38	7	0	0-62	2	0	0-100	7	14	0-69	4	0	0-95
GOOD SHEPHERD MEDICAL CENT LONGVIEW TX 75601	29	14	11-48	10	20	13-69	86	7	4-18	3	33	0-100	248	5	2-9	119	8	2-13	15	0	0-89	209	4	3-10	120	2	0-7
GOODALL - WITCHER HOSPITAL CLIFTON TX 76634	6	33	4-70	2	0	2-90	21	14	2-31	.	.		78	4	2-13	29	7	1-24	8	0	0-100	44	2	1-16	11	0	0-83
GRAHAM GENERAL HOSP GRAHAM TX 76046	9	44	10-69	9	78	11-68	.	.		.	.		51	4	1-16	19	0	0-31	1	0	0-100	33	6	1-20	8	13	0-78
GRANVILLE C MORTON HOSPITA DALLAS TX 75235	1	0	0-98	1	100	1-97	1	0	0-100	.	.		9	0	0-50	2	0	0-100	2	0	0-100	5	0	0-75	9	0	0-90
GUADALUPE VALLEY HOSP SEGUIN TX 78155	7	29	7-70	6	50	13-80	25	8	2-29	5	0	0-100	108	5	1-11	44	5	1-19	12	0	0-99	45	9	1-17	46	2	0-20
GULF COAST HOSPITAL BAYTOWN TX 77521	6	67	6-72	6	0	7-72	35	14	2-23	10	10	0-100	63	10	1-14	35	0	1-21	3	0	0-100	26	0	1-23	40	5	0-18
GULF COAST MEDICAL CENTER WHARTON TX 77488	9	0	4-59	16	44	16-62	22	9	2-29	3	0	0-100	85	4	2-12	49	8	2-19	14	0	0-99	65	2	1-14	25	0	0-30
HALL CO HOSP MEMPHIS TX 79245	1	100	2-98	.	.		1	0	1-97	.	.		21	0	1-28	5	0	0-73	1	0	0-100	12	0	0-42	9	0	0-88
HALL-BENNETT MEMORIAL HOSP BIG SPRING TX 79721	10	60	7-62	.	.		12	17	1-42	.	.		52	10	2-17	9	11	1-50	5	0	0-100	29	0	1-21	9	11	0-73
HALTOM HOSPITAL FORT WORTH TX 76117	1	0	0-99	1	100	0-97	1	0	0-100	.	.		13	0	0-41	8	13	0-62	.	.		12	0	0-45	1	0	0-99
HAMILTON GENERAL HOSPITAL HAMILTON TX 76531	1	0	0-97	3	67	5-86	8	25	1-53	1	0	0-100	27	4	1-23	9	0	0-62	2	0	0-100	24	13	1-26	8	0	0-91
HAMILTON HOSPITAL OLNEY TX 76374	10	20	5-59	2	0	2-90	14	7	2-40	1	0	0-100	40	5	1-17	16	0	0-45	5	0	0-100	18	6	0-31	10	0	0-79
HAMLIN MEM HOSP HAMLIN TX 79520	4	0	1-77	.	.		1	0	0-100	.	.		12	0	0-49	6	0	0-69	1	0	0-100	17	0	1-32	2	50	0-100

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																							
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HANSFORD HOSPITAL SPEARMAN TX 79081	TX-195*	90	20	7-22	1	100	0-97	1	100	0-97	2	0	2-89	5	40	2-68	1	100	1-97	1	0	0-97	24	21	7-40
HARDIN MEMORIAL HOSP KDUNTZE TX 77625	TX-196*	4	0	1-74	.	.		.	.		1	0	1-97	.	.		.	.		.	.		.	.	
HARRIS COUNTY HOSPITAL DIS HOUSTON TX 77019	TX-197	1247	16	6-13	85	32	13-34	22	18	11-47	28	21	7-37	79	20	12-30	37	38	21-52	29	21	7-38	110	22	8-24
HARRIS METHODIST FORT WORT FORT WORTH TX 76104	TX-198	3959	11	8-14	289	21	17-32	121	26	21-38	70	14	9-30	176	26	15-28	176	36	29-46	55	27	8-32	224	21	13-26
HARRIS METHODIST H E B BEDFORD TX 76022	TX-199	758	11	8-16	61	21	14-39	29	17	13-45	16	19	6-45	28	18	10-41	49	47	26-54	13	8	3-47	66	18	9-29
HARRIS METHDDIST MEXIA MEXIA TX 76667	TX-200	290	18	10-20	11	36	11-62	14	29	12-57	6	0	1-63	18	22	9-48	23	57	23-62	4	25	1-74	50	10	9-31
HARRIS METHODIST NORTHWEST AZLE TX 76020	TX-201	162	22	9-21	5	20	4-73	5	60	4-71	3	33	3-83	7	14	2-59	12	50	17-67	4	50	2-74	32	19	9-38
HARRIS METHODIST STEPHENVI STEPHENVILLE TX 76401	TX-202	585	19	11-20	22	27	13-52	21	52	16-55	18	17	8-48	34	41	13-42	28	46	24-60	22	32	9-45	75	24	15-35
HASKELL MEMORIAL HOSP HASKELL TX 79521	TX-203*	145	30	11-25	1	0	0-97	20	65	12-50	5	0	1-68	11	27	7-56	17	41	15-58	12	33	10-60	15	33	5-44
HAYS MEMDRIAL HDSP SAN MARCOS TX 78667	TX-204*	638	12	9-17	35	23	12-42	32	25	16-47	9	33	3-54	30	17	9-38	22	36	20-60	22	9	4-38	85	22	13-32
HCA CORDNADO HDSPITAL PAMPA TX 79065	TX-205*	928	8	8-16	48	21	14-41	21	29	14-53	17	12	5-44	39	3	12-38	50	20	27-54	18	11	5-43	118	11	12-28
HCA DOCTORS HOSPITAL CONROE TX 77304	TX-206	540	12	9-17	34	21	12-42	24	25	12-46	15	33	5-46	31	29	11-40	17	35	19-63	14	21	7-51	70	16	11-31
HCA LONGVIEW REGIONAL HDSP LONGVIEW TX 75601	TX-207*	757	12	9-16	54	19	15-41	27	33	14-47	15	13	5-46	24	17	9-43	32	41	22-56	21	19	8-45	50	16	10-33
HCA MANSFIELD HOSPITAL MANSFIELD TX 76063	TX-208*	167	16	7-19	5	20	1-68	4	50	4-77	6	0	3-65	8	25	4-59	8	50	13-72	8	0	5-62	24	33	7-39
HCA MEDICAL CENTER OF PLAN PLANO TX 75075	TX-209	808	13	8-16	50	20	10-35	29	21	14-46	12	17	4-50	39	21	11-37	21	43	22-63	18	33	6-44	85	27	11-30
HCA MIDWAY PARK MEDCIAL CE LANCASTER TX 75146	TX-210	558	19	10-18	29	41	10-42	25	48	13-48	10	20	4-54	21	38	8-42	35	40	26-58	26	31	9-43	56	23	11-33
HCA NORTH HILLS MEDICAL CE NORTH RICHARD HILLS TX 76118	TX-211	876	14	10-17	28	21	10-43	32	28	15-47	14	21	2-42	62	19	14-36	52	33	25-52	24	8	7-40	98	33	13-31
HCA NORTHEAST COMMUNITY HO BEDFORD TX 76021	TX-212	590	11	7-15	27	30	10-42	22	27	14-51	8	25	2-55	46	28	12-36	16	44	17-62	15	13	5-46	48	13	8-30
HCA PASADENA BAYSHORE MEDI PASADENA TX 77504	TX-213*	1339	13	9-16	85	24	15-37	54	24	15-39	36	25	8-36	81	32	13-32	62	42	25-50	37	27	9-37	142	14	11-26
HCA RIO GRANDE REGIONAL HO MC ALLEN TX 78503	TX-214	1557	14	9-16	118	31	17-36	52	31	16-41	40	18	7-33	67	22	14-35	34	53	23-55	31	19	8-39	176	27	13-28
HCA SDUTH ARLINGTDN MEDICA ARLINGTDN TX 76015	TX-215	556	11	8-16	25	36	13-48	21	24	13-51	8	13	3-57	40	30	12-38	25	48	22-59	9	22	2-53	53	13	9-31
HCA SDUTH AUSTIN MEDICAL C AUSTIN TX 78704	TX-216*	898	13	9-16	35	17	12-42	22	23	13-50	19	26	7-45	51	29	13-36	25	48	21-58	41	12	8-35	102	25	13-30
HCA SUN TDWERS HDSPITAL EL PASD TX 79902	TX-217*	1105	11	8-15	53	19	15-40	30	30	16-48	23	13	8-43	36	22	11-38	29	34	21-55	36	17	10-40	96	27	16-35
HCA VALLEY REGIONAL MEDICA BRDWNSVILLE TX 78521	TX-218*	596	13	9-17	32	28	10-40	23	43	13-49	17	24	3-40	52	17	13-36	29	38	21-55	33	15	9-39	44	23	9-34
HCA VISTA HILLS MEDICAL CE EL PASD TX 79925	TX-219*	1055	13	9-16	54	33	19-46	31	45	15-46	24	25	7-40	46	4	11-36	42	43	25-55	33	18	8-37	127	20	12-28
HCA WOODLAND HEIGHTS MEDIC LUFKIN TX 75901	TX-220	908	9	8-15	40	15	11-40	34	32	17-48	21	10	7-42	36	22	10-37	29	24	24-59	27	11	7-40	93	16	11-29

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Dphthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HANSFORD HOSPITAL SPEARMAN TX 79081	7	14	3-64	.	.		.	.		.	.		11	18	1-44	3	0	0-84	.	.		3	33	0-88	.	.	
HARDIN MEMORIAL HOSP KOUNTZE TX 77625	.	.		.	.		.	.		.	.		1	0	0-100	.			.	.		.	.		.	.	
HARRIS COUNTY HOSPITAL DIS HOUSTON TX 77019	12	17	4-53	9	78	13-70	15	13	1-36	11	9	0-99	64	13	2-15	94	6	1-13	9	0	0-65	81	9	1-11	34	6	0-25
HARRIS METHODIST FORT WORTH FORT WORTH TX 76104	38	11	5-38	28	50	19-55	147	5	4-14	8	13	0-100	364	5	3-9	204	5	1-10	65	2	0-13	483	7	3-7	378	1	0-4
HARRIS METHODIST H E B BEDFORD TX 76022	3	0	3-83	8	38	12-72	20	5	2-31	4	0	0-100	79	9	2-13	38	0	0-20	4	0	0-100	50	2	1-15	42	5	0-16
HARRIS METHODIST MEXIA MEXIA TX 76667	9	56	4-59	6	33	7-72	5	20	1-68	.	.		32	6	1-20	13	23	1-40	2	0	0-100	13	8	0-39	7	0	0-92
HARRIS METHODIST NORTHWEST AZLE TX 76020	3	67	2-83	.	.		4	0	0-77	.	.		25	16	2-26	4	25	1-74	.	.		21	5	0-27	4	0	0-100
HARRIS METHODIST STEPHENVI STEPHENVILLE TX 76401	19	37	10-54	4	50	5-80	30	23	3-28	5	0	0-99	93	14	2-13	23	9	1-29	6	0	0-100	44	11	2-18	19	0	0-36
HASKELL MEMORIAL HOSP HASKELL TX 79521	2	50	4-93	.	.		1	0	0-100	.	.		10	10	0-47	.	.		1	0	0-100	8	25	0-62	6	0	0-99
HAYS MEMORIAL HOSP SAN MARCOS TX 78667	5	60	5-75	7	29	13-76	28	4	4-30	8	0	0-100	81	5	1-12	42	0	0-19	11	0	0-100	43	5	1-17	20	5	0-43
HCA CORONADO HOSPITAL PAMPA TX 79065	12	17	5-55	4	50	7-82	32	3	2-24	3	0	0-100	113	3	1-10	72	6	1-15	13	0	0-97	127	2	2-10	32	0	0-21
HCA DOCTORS HOSPITAL CONROE TX 77304	4	25	2-76	4	50	8-83	14	7	1-38	2	0	0-100	61	2	1-14	39	0	1-20	4	0	0-100	60	0	1-14	24	4	0-28
HCA LONGVIEW REGIONAL HOSP LONGVIEW TX 75601	9	33	5-62	14	43	14-63	30	10	3-28	5	0	0-100	83	5	2-14	64	8	1-16	9	0	0-100	44	7	1-17	62	2	0-11
HCA MANSFIELD HOSPITAL MANSFIELD TX 76063	4	75	9-85	1	0	0-98	8	0	1-54	.	.		24	0	0-26	6	0	0-75	1	0	0-100	12	8	1-41	8	0	0-93
HCA MEDICAL CENTER OF PLAN PLANO TX 75075	10	20	9-65	10	40	12-67	37	3	3-24	2	0	0-100	89	8	2-13	30	10	0-23	8	0	0-100	65	8	2-14	63	0	0-12
HCA MIDWAY PARK MEDCIAL CE LANCASTER TX 75146	7	71	8-72	10	40	18-74	14	7	1-38	4	0	0-100	62	10	1-14	18	0	0-33	1	0	0-100	80	4	1-12	9	11	0-79
HCA NORTH HILLS MEDICAL CE NORTH RICHARD HILLS TX 76118	9	11	3-58	25	36	19-58	41	2	2-21	.	.		96	9	3-14	34	6	1-21	6	0	0-100	91	3	2-12	50	2	0-14
HCA NORTHEAST COMMUNITY HD BEDFORD TX 76021	5	20	3-72	6	17	11-77	11	9	1-44	1	0	0-100	67	4	2-14	17	6	0-37	7	0	0-100	57	4	1-14	50	4	0-14
HCA PASADENA BAYSHORE MEDI PASADENA TX 77504	21	33	10-52	9	44	16-74	40	8	3-24	8	0	0-100	113	9	2-12	54	7	1-17	19	0	0-77	128	5	2-10	48	2	0-16
HCA RIO GRANDE REGIONAL HD MC ALLEN TX 78503	24	21	8-48	21	43	20-62	28	4	2-27	10	0	0-100	190	3	3-11	125	2	1-11	11	0	0-74	134	5	2-10	82	2	0-9
HCA SOUTH ARLINGTON MEDICA ARLINGTON TX 76015	9	33	3-59	3	0	4-85	20	0	2-33	6	0	0-86	61	2	1-13	14	7	0-38	9	0	0-98	58	2	2-15	37	0	0-23
HCA SOUTH AUSTIN MEDICAL C AUSTIN TX 78704	10	30	4-57	23	35	17-57	42	10	3-23	8	0	0-100	82	4	2-13	49	4	1-18	8	0	0-100	60	5	2-15	62	0	0-11
HCA SUN TOWERS HOSPITAL EL PASO TX 79902	17	41	8-53	7	0	6-67	24	8	2-29	16	0	0-99	119	4	3-12	72	4	1-14	5	0	0-100	111	5	1-10	60	3	0-12
HCA VALLEY REGIONAL MEDICA BROWNSVILLE TX 78521	10	10	7-61	11	9	10-62	7	14	0-65	8	0	0-100	81	2	2-13	42	5	1-20	3	0	0-100	37	3	1-18	19	0	0-54
HCA VISTA HILLS MEDICAL CE EL PASO TX 79925	14	29	8-56	8	25	10-69	21	10	2-32	3	0	0-100	146	6	2-11	64	3	1-15	13	8	0-53	122	10	2-10	32	0	0-22
HCA WOODLAND HEIGHTS MEDIC LUFKIN TX 75901	7	14	5-67	5	20	6-76	40	3	2-22	2	0	0-100	98	2	2-12	97	3	2-13	9	0	0-100	108	2	2-11	55	2	0-14

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HCA WYSONG MEDICAL CENTER MCKINNEY TX 75069	TX-221	450	12	10-19	25	20	12-47	26	15	14-48	9	11	6-59	17	29	9-48	15	40	19-65	17	0	6-45	53	19	13-37
HEMPHILL CO HOSP CANADIAN TX 79014	TX-222	63	17	8-26	1	0	1-97	7	29	8-69	.	.		3	0	4-84	3	67	8-89	3	0	0-82	14	36	5-46
HENDERICK MEDICAL CENTER ABILENE TX 79601	TX-223	2748	13	10-16	295	23	20-35	113	27	19-37	53	15	10-34	114	28	15-32	87	45	28-50	38	11	9-37	205	26	15-29
HENDERSON MEM HOSP HENDERSON TX 75652	TX-224*	814	17	10-18	37	27	13-42	63	46	18-41	21	29	5-39	77	31	15-35	34	38	24-57	35	26	7-35	78	19	12-32
HERMANN HOSPITAL HOUSTON TX 77030	TX-225	2415	13	7-14	129	20	18-36	101	28	17-36	44	16	7-31	95	17	12-29	73	40	27-51	69	33	12-35	132	25	14-30
HI-PLAINS HOSP HALE CENTER TX 79041	TX-226*	161	6	6-18	3	33	1-81	4	0	4-77	8	13	2-55	6	17	4-66	7	29	11-73	3	0	2-82	29	3	5-32
HICO CITY HOSP HICO TX 76457	TX-227*	160	19	8-20	2	50	2-90	8	25	8-66	7	43	4-62	6	17	4-66	2	50	2-90	5	40	6-76	31	32	9-38
HIGH PLAINS BAPTIST HOSP AMARILLO TX 79106	TX-228	2029	7	7-14	149	13	14-32	79	23	19-39	42	24	8-34	76	18	13-32	71	21	27-50	33	6	6-35	118	16	13-29
HIGHLAND HOSPITAL LUBBOCK TX 79412	TX-229*	400	11	6-15	19	21	8-46	11	9	8-58	11	18	4-51	11	27	8-58	6	50	10-76	8	13	2-57	43	23	9-34
HILL COUNTRY MEMORIAL HOSP FREDERICKSBURG TX 78624	TX-230	621	9	10-18	40	20	12-41	24	29	16-52	25	16	12-47	25	20	11-45	19	32	21-64	13	0	7-52	69	17	13-34
HILL REGIONAL HOSPITAL HILLSBORO TX 76645	TX-231	417	15	10-18	9	33	4-57	15	33	12-56	6	17	2-63	37	38	12-40	27	52	22-59	14	21	3-44	67	13	11-32
HILLCREST BAPTIST MEDICAL WACO TX 76708	TX-232	2902	15	10-16	272	24	17-32	149	33	20-36	68	25	10-31	122	30	17-33	104	51	30-51	56	23	12-37	223	25	13-26
HOLY CROSS HOSP AUSTIN TX 78702	TX-233	304	19	9-18	20	40	12-51	6	17	7-71	7	0	2-59	14	36	9-52	2	50	5-93	9	22	5-59	23	43	9-43
HOOD GENERAL HOSP GRANBURY TX 76048	TX-234*	467	16	9-18	21	24	11-50	22	32	13-50	9	22	5-57	38	29	11-38	15	53	15-60	17	18	5-44	58	36	12-34
HOPKINS CO MEM HOSP SULPHUR SPRINGS TX 75482	TX-235	653	18	11-19	24	33	9-44	37	51	15-44	19	5	5-40	37	41	13-40	47	30	25-53	22	14	6-42	78	24	14-35
HOSPITAL IN THE PINES INC LONE STAR TX 75668	TX-236*	189	14	7-18	2	50	1-89	5	20	6-74	5	0	1-68	9	44	5-57	10	50	18-73	1	0	0-99	20	30	6-41
HOTEL DIEU MEDICAL CENTER EL PASO TX 79902	TX-237*	1458	11	9-15	75	31	17-40	43	16	16-44	24	17	6-39	51	16	12-35	27	37	24-61	57	21	10-35	117	22	14-31
HOUSTON CO HOSP CROCKETT TX 75835	TX-238	507	18	10-19	23	30	13-50	23	39	13-49	9	22	3-55	34	32	11-40	23	35	19-58	32	41	7-36	78	18	13-33
HOUSTON NORTHWEST MEDICAL HOUSTON TX 77090	TX-239	1602	12	9-15	110	25	17-37	40	20	14-41	29	14	6-36	92	24	14-31	71	46	27-51	38	3	4-30	145	25	12-27
HUBBARD HOSPITAL HUBBARD TEXAS 76648	TX-240*	2	0	1-89	.	.		.	.		.	.		.	.		1	0	1-97	.	.		.	.	
HUBBARD HOSPITAL HUBBARD TX 76648	TX-241*	84	13	8-24	2	50	6-94	3	0	3-83	2	0	0-90	10	10	5-54	4	75	7-81	5	0	1-69	21	5	5-39
HUGULEY MEMORIAL HOSP FORT WORTH TX 76115	TX-242	908	15	9-17	61	25	12-36	27	26	16-50	20	20	3-37	49	20	11-34	22	36	22-62	42	19	8-35	141	24	15-30
HUMANA HOSP CORPUS CHRISTI CORPUS CHRISTI TX 78411	TX-243	1478	9	7-13	67	22	15-38	49	29	16-42	30	13	7-36	41	20	11-37	29	34	21-55	37	24	7-35	127	17	12-27
HUMANA HOSP METROPOLITAN SAN ANTONIO TX 78212	TX-244	1596	9	8-15	123	24	19-38	41	22	22-51	25	8	5-37	91	13	15-33	50	32	26-54	33	9	8-38	95	19	11-28
HUMANA HOSPITAL ABILENE ABILENE TX 79606	TX-245	1608	14	9-16	119	25	17-36	67	18	19-42	32	34	12-43	62	26	13-35	92	46	27-48	50	20	6-31	143	18	12-27
HUMANA HOSPITAL BAYTOWN BAYTOWN TX 77520	TX-246*	790	11	9-16	24	29	16-53	40	13	17-46	22	5	7-41	57	18	13-35	30	43	25-60	18	11	7-47	86	13	11-29

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HCA WYSONG MEDICAL CENTER MCKINNEY TX 75069	15	13	12-60	14	71	16-64	24	8	2-30	.	.		58	7	2-15	19	11	0-31	11	0	0-96	39	3	1-19	13	0	0-65
HEMPHILL CO HOSP CANADIAN TX 79014	.	.		.	.		.	.		.	.		8	0	0-55	.	.		1	0	0-100	4	25	0-81	2	0	0-100
HENDERICK MEDICAL CENTER ABILENE TX 79601	27	30	11-50	37	62	26-59	160	9	6-17	7	0	0-100	304	7	3-9	184	2	2-11	42	0	0-47	173	3	3-10	235	0	0-5
HENDERSON MEM HOSP HENDERSON TX 75652	7	29	6-68	20	40	15-57	28	7	1-25	5	0	0-100	62	6	2-15	29	7	1-24	6	0	0-100	75	4	1-12	15	0	0-54
HERMANN HOSPITAL HOUSTON TX 77030	61	13	5-35	10	70	15-71	53	19	3-20	76	0	0-10	171	10	3-10	120	5	1-12	14	0	0-99	194	9	2-9	118	1	0-7
HI-PLAINS HOSP HALE CENTER TX 79041	4	25	3-77	3	33	4-85	6	17	1-62	.	.		21	0	0-29	3	0	0-91	.	.		10	0	0-50	10	0	0-71
HICO CITY HOSP HICO TX 76457	4	25	6-81	.	.		1	0	0-99	.	.		16	0	0-34	4	0	0-82	.	.		9	22	1-49	5	0	0-98
HIGH PLAINS BAPTIST HOSP AMARILLO TX 79106	9	22	7-64	13	23	16-66	81	4	3-16	75	1	0-19	190	2	3-10	96	5	2-13	26	0	0-96	199	3	3-9	190	1	0-5
HIGHLAND HOSPITAL LUBBOCK TX 79412	6	50	6-72	4	25	8-83	15	7	3-41	.	.		61	7	2-15	14	14	1-38	12	0	0-99	7	0	0-59	74	0	0-10
HILL COUNTRY MEMORIAL HOSP FREDERICKSBURG TX 78624	8	13	10-70	6	17	12-79	37	5	3-24	.	.		77	1	1-13	57	7	2-17	4	0	0-100	52	2	2-16	19	0	0-39
HILL REGIONAL HOSPITAL HILLSBORO TX 76645	5	0	3-72	4	25	7-82	18	22	3-36	.	.		38	3	1-18	14	7	1-38	8	0	0-94	45	2	1-17	12	0	0-74
HILLCREST BAPTIST MEDICAL WACO TX 76708	35	23	14-51	32	50	23-59	152	9	5-16	18	0	0-82	355	6	4-9	227	7	2-11	60	0	0-21	140	5	2-10	194	2	0-5
HOLY CROSS HOSP AUSTIN TX 78702	5	60	4-74	6	83	14-81	7	14	0-59	.	.		18	6	0-31	14	14	1-38	.	.		10	20	0-47	19	0	0-31
HOOD GENERAL HOSP GRANBURY TX 76048	6	17	4-69	7	29	7-69	16	6	1-35	5	0	0-100	76	3	1-13	19	11	2-33	2	0	0-100	49	2	1-16	16	0	0-68
HOPKINS CO MEM HOSP SULPHUR SPRINGS TX 75482	13	15	6-55	8	50	14-74	10	0	0-50	2	0	0-100	86	9	2-13	17	6	1-34	9	0	0-100	57	4	1-14	20	0	0-50
HOSPITAL IN THE PINES INC LONE STAR TX 75668	3	67	4-85	.	.		3	0	0-86	.	.		25	4	1-25	15	13	2-38	.	.		22	0	1-26	5	0	0-86
HOTEL DIEU MEDICAL CENTER EL PASO TX 79902	51	22	8-39	25	28	22-61	29	7	2-25	16	6	0-74	179	5	3-11	105	4	2-13	6	0	0-99	116	6	2-11	66	0	0-11
HOUSTON CO HOSP CROCKETT TX 75835	14	21	9-58	10	40	15-70	17	6	1-34	.	.		50	8	1-16	24	13	1-27	1	0	0-100	39	8	1-18	10	0	0-88
HOUSTON NORTHWEST MEDICAL HOUSTON TX 77090	15	20	9-57	33	30	21-55	44	16	3-22	2	50	0-100	147	4	2-11	74	5	2-16	16	0	0-100	197	3	2-8	124	1	0-7
HUBBARD HOSPITAL HUBBARD TEXAS 76648	.	.		.	.		.	.		.	.		1	0	0-100	.	.		.	.		.	.		.	.	
HUBBARD HOSPITAL HUBBARD TX 76648	1	100	1-97	.	.		1	0	0-98	.	.		9	11	0-57	1	0	0-100	.	.		2	0	0-99	2	0	0-100
HUGULEY MEMORIAL HOSP FORT WORTH TX 76115	6	67	8-75	15	47	16-64	37	11	3-24	1	0	0-100	100	11	2-13	53	13	2-19	6	0	0-99	52	2	1-14	55	0	0-14
HUMANA HOSP CORPUS CHRISTI CORPUS CHRISTI TX 78411	16	6	5-50	14	50	18-67	62	5	3-19	17	0	0-92	155	5	2-11	51	10	1-17	13	0	0-99	101	4	1-10	244	0	0-4
HUMANA HOSP METROPOLITAN SAN ANTONIO TX 78212	15	33	10-58	15	47	18-65	51	2	3-20	2	0	0-100	159	3	3-11	36	8	1-21	15	0	0-99	192	4	2-9	195	1	0-5
HUMANA HOSPITAL ABILENE ABILENE TX 79606	14	43	13-63	15	47	16-63	45	13	3-22	5	0	0-100	152	7	3-11	55	7	1-16	6	0	0-95	273	4	2-8	58	3	0-12
HUMANA HOSPITAL BAYTOWN BAYTOWN TX 77520	13	15	5-53	4	25	5-80	16	6	1-35	1	0	0-100	108	3	2-12	35	9	0-21	13	0	0-98	63	13	2-14	39	5	1-17

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/Location	Comment/Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HUMANA HOSPITAL BRYAN COLL BRYAN TX 77802	TX-247	693	15	9-16	63	27	13-36	36	25	16-46	11	18	3-50	34	26	14-43	25	72	23-61	12	25	2-47	50	28	9-33
HUMANA HOSPITAL CLEAR LAKE WEBSTER TX 77598	TX-248	1291	11	9-16	94	29	18-39	36	19	15-45	25	4	8-41	65	37	14-35	36	31	24-56	24	13	10-46	103	23	14-32
HUMANA HOSPITAL MEDICAL CI DALLAS TX 75230	TX-249	2153	10	7-13	178	24	16-32	69	25	17-39	38	18	6-32	78	24	14-33	43	23	21-50	48	21	8-34	117	26	11-27
HUMANA HOSPITAL SAN ANTONI SAN ANTONIO TX 78229	TX-250	2519	9	7-13	130	22	16-35	68	31	20-43	56	14	8-30	110	22	16-33	61	38	27-52	47	17	9-35	162	23	13-28
HUMANA HOSPITAL SOUTHMORE PASADENA TX 77502	TX-251	786	13	9-16	42	24	16-45	23	43	16-53	21	24	5-40	49	27	14-38	14	50	18-66	27	26	9-42	81	22	13-32
HUMANA WOMENS HOSPITAL SOU SAN ANTONIO TX 78229	TX-252	21	0	0-31	3	0	1-81	.	.		.	.		.	.		.	.		.	.		.	.	
HUNTSVILLE MEM HOSP HUNTSVILLE TX 77340	TX-253*	1063	10	8-16	47	21	11-38	42	26	17-45	20	15	5-41	43	19	12-37	14	21	15-63	43	28	13-41	121	21	14-31
IRVING COMM HOSP IRVING TX 75061	TX-254	1392	13	8-15	69	33	13-36	32	28	16-47	30	10	6-36	100	30	14-31	63	41	25-50	35	34	9-39	123	20	12-28
JACK CO HOSP JACKSBORO TX 76056	TX-255*	143	17	9-22	10	40	8-60	3	33	6-86	3	33	4-85	9	44	8-62	12	25	15-65	1	0	0-97	14	21	10-54
JASPER MEMORIAL HOSP JASPER TX 75951	TX-256*	306	16	10-20	19	37	10-49	10	20	9-61	12	8	8-56	20	25	8-43	13	46	13-61	13	23	8-54	48	17	12-36
JOHN PETER SMITH HOSP FORT WORTH TX 76104	TX-257	676	18	6-14	31	39	15-48	17	47	8-48	20	35	3-37	44	27	10-34	33	67	19-51	23	13	5-38	59	24	7-27
JOHNS COMM HOSP TAYLOR TX 76574	TX-258*	549	13	9-18	23	17	12-48	32	38	15-46	21	29	5-39	31	29	12-42	15	40	19-65	27	30	10-44	73	15	12-32
KARNES CITY HOSPITAL INC KARNES CITY TX 78118	TX-259*	29	38	6-34	5	60	2-69	3	100	5-85	.	.		3	67	4-84	1	100	1-97	.	.		2	50	1-89
KIMBLE HOSPITAL JUNCTION TX 76849	TX-260*	92	15	7-22	.	.		1	0	0-97	1	0	0-99	2	50	1-89	4	50	11-87	6	50	3-65	19	21	7-44
KING WILLIAM HEALTH CARE C SAN ANTONIO TX 78204	TX-261	160	13	5-16	1	100	0-98	2	50	3-91	.	.		6	67	5-68	.	.		1	100	1-97	17	24	8-48
KINGS DAUGHTERS HOSP TEMPLE TX 76502	TX-262*	1021	12	11-18	81	25	20-42	51	35	19-44	31	16	8-38	57	25	12-34	42	36	26-56	30	33	11-44	86	15	12-31
KIRBYVILLE COMMUNITY HOSPI KIRBYVILLE TEXAS 75956	TX-263*	165	13	11-23	4	50	4-77	4	75	5-79	1	0	0-97	9	22	7-61	4	25	10-85	9	44	9-65	46	15	13-38
KNAPP MEM METHODIST HOSP WESLACO TX 78596	TX-264	941	15	9-16	40	38	10-38	44	34	18-45	23	9	6-38	50	40	12-35	26	58	23-60	25	28	7-41	96	20	13-31
KNOX CO HOSP DISTRICT KNOX CITY TX 79529	TX-265*	75	25	8-26	4	100	9-84	4	25	3-76	.	.		2	50	1-89	4	0	7-82	2	50	2-90	11	55	7-56
LAKE CLIFF HOSPITAL DALLAS TX 75203	TX-266	86	8	3-16	6	33	2-64	2	100	1-89	2	50	1-89	9	0	3-53	.	.		3	0	1-81	3	0	0-86
LAKE LIVINGSTON MEDICAL CE LIVINGSTON TX 77351	TX-267	401	16	9-18	8	38	7-64	10	50	10-63	20	10	4-38	25	20	9-42	28	29	22-58	17	41	7-47	62	19	9-29
LAKE WHITNEY MEMORIAL HOSP WHITNEY TX 76692	TX-268*	276	18	11-22	11	36	8-58	13	31	12-59	5	20	8-78	21	33	10-46	25	68	26-64	14	14	5-47	30	23	10-41
LAKELAND MEDICAL CENTER ATHENS TX 75751	TX-269	892	13	9-17	45	36	14-41	42	26	15-42	23	17	6-40	55	22	13-35	30	57	23-57	31	29	8-39	112	15	13-30
LAVACA MEDICAL CENTER HALLETTSVILLE TX 77964	TX-270*	159	18	10-22	10	40	6-57	6	33	6-71	6	17	4-67	12	25	8-54	3	100	6-87	2	0	1-89	19	21	13-53
LEE MEMORIAL HOSPITAL GIDDINGS TX 78942	TX-271*	169	18	10-22	7	29	7-68	4	0	6-80	6	0	2-63	14	29	7-50	6	33	12-79	12	17	4-50	27	22	9-40
LEON COUNTY MEMORIAL HOSPI BUFFALO TX 75831	TX-272*	130	17	10-24	2	100	2-90	7	29	8-69	2	0	0-91	6	50	4-67	9	44	21-79	5	20	2-69	30	13	9-39

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HUMANA HOSPITAL BRYAN COLL BRYAN TX 77802	9	44	7-63	5	50	9-75	22	14	2-30	13	0	0-99	83	6	2-13	39	5	1-20	7	0	0-100	50	10	2-16	35	6	0-25
HUMANA HOSPITAL CLEAR LAKE WEBSTER TX 77598	15	33	8-55	19	37	18-61	33	15	2-24	5	0	0-100	178	3	2-10	87	2	1-14	11	0	0-99	94	3	2-11	65	3	0-11
HUMANA HOSPITAL MEDICAL CI DALLAS TX 75230	14	29	5-52	13	38	20-71	50	4	2-19	29	0	0-93	159	5	2-9	86	5	1-13	25	0	0-95	404	4	3-7	124	2	0-7
HUMANA HOSPITAL SAN ANTONI SAN ANTONIO TX 78229	40	0	1-37	18	33	16-59	74	8	3-18	26	0	0-80	216	7	3-9	144	4	2-12	14	0	0-99	351	5	3-8	223	2	0-5
HUMANA HOSPITAL SOUTHMORE PASADENA TX 77502	16	38	7-53	9	11	9-65	17	6	3-38	5	0	0-100	92	5	1-12	53	6	1-16	5	0	0-100	48	8	1-16	38	3	0-18
HUMANA WOMENS HOSPITAL SOU SAN ANTONIO TX 78229	.	.		.	.		.	.		.	.		1	0	0-100	.	.		11	0	0-99	.	.		3	0	0-100
HUNTSVILLE MEM HOSP HUNTSVILLE TX 77340	13	46	11-62	19	26	18-62	34	9	3-25	6	0	0-100	114	3	2-11	66	5	2-17	8	0	0-100	104	5	2-12	82	1	0-10
IRVING COMM HOSP IRVING TX 75061	11	18	4-56	11	55	18-72	26	27	4-31	3	0	0-100	118	3	2-11	76	9	1-14	19	0	0-93	188	4	2-9	56	0	0-13
JACK CO HOSP JACKSBORO TX 76056	1	100	0-97	.	.		.	.		.	.		13	8	0-40	11	9	0-51	1	0	0-100	30	0	1-22	2	0	0-100
JASPER MEMORIAL HOSP JASPER TX 75951	4	50	4-79	8	25	13-74	2	0	0-57	.	.		45	4	1-16	5	0	0-75	7	0	0-100	30	0	1-22	11	0	0-53
JOHN PETER SMITH HOSP FORT WORTH TX 76104	5	40	1-71	3	100	1-61	14	29	1-38	9	0	0-100	42	14	2-19	19	16	1-31	4	0	0-100	44	7	0-15	18	0	0-56
JOHNS COMM HOSP TAYLOR TX 76574	4	0	3-77	7	29	10-73	28	0	2-26	1	0	0-100	62	8	2-15	26	4	1-25	4	0	0-100	34	6	1-19	22	5	0-27
KARNES CITY HOSPITAL INC KARNES CITY TX 78118	.	.		1	0	1-97	.	.		.	.		5	0	0-72	.	.		1	0	0-100	.	.		.	.	
KIMBLE HOSPITAL JUNCTION TX 76849	4	0	3-76	3	33	4-84	2	0	0-99	.	.		9	0	0-53	.	.		.	.		15	0	1-35	4	0	0-99
KING WILLIAM HEALTH CARE C SAN ANTONIO TX 78204	1	100	1-97	2	100	3-91	1	0	0-99	.	.		4	50	0-65	7	14	0-62	.	.		2	0	0-89	10	0	0-85
KINGS DAUGHTERS HOSP TEMPLE TX 76502	10	0	7-52	15	25	12-65	29	7	3-23	4	0	0-100	121	7	3-13	29	0	1-24	25	0	0-83	77	8	2-13	75	0	0-10
KIRBYVILLE COMMUNITY HOSPI KIRBYVILLE TEXAS 75956	3	33	4-85	1	100	1-97	.	.		.	.		5	0	0-74	5	0	0-81	.	.		18	0	1-81	2	0	0-100
KNAPP MEM METHODIST HOSP WESLACO TX 78596	6	33	5-72	10	10	9-63	38	8	3-24	18	0	0-87	129	3	2-10	83	5	2-15	9	0	0-70	48	4	2-16	42	2	0-16
KNOX CO HOSP DISTRICT KNOX CITY TX 79529	1	0	1-97	1	0	1-97	.	.		.	.		7	29	0-65	3	0	1-81	.	.		4	0	0-84	3	0	0-99
LAKE CLIFF HOSPITAL DALLAS TX 75208	.	.		1	100	1-97	.	.		.	.		10	10	0-57	5	0	0-74	.	.		4	0	0-63	16	0	0-65
LAKE LIVINGSTON MEDICAL CE LIVINGSTON TX 77351	7	43	7-53	1	0	1-97	2	0	0-90	.	.		56	2	1-14	11	27	1-44	4	0	0-100	54	4	1-15	7	14	0-22
LAKE WHITNEY MEMORIAL HOSP WHITNEY TX 76692	4	25	2-77	1	0	3-99	3	0	1-81	.	.		40	5	1-18	7	14	0-67	.	.		30	0	1-21	11	0	0-67
LAKELAND MEDICAL CENTER ATHENS TX 75751	10	20	5-59	9	33	12-69	20	15	2-32	1	100	0-100	102	5	1-11	66	5	3-15	10	0	0-95	80	1	2-12	31	0	0-21
LAVACA MEDICAL CENTER HALLETTSVILLE TX 77964	4	25	5-80	4	50	6-80	7	14	1-57	.	.		14	14	0-39	8	0	0-62	2	0	0-100	11	18	0-45	1	0	0-100
LEE MEMORIAL HOSPITAL GIDDINGS TX 78942	1	0	0-95	6	33	11-77	5	0	1-58	.	.		13	8	1-39	9	44	1-50	3	33	0-82	15	0	0-37	3	0	0-97
LEON COUNTY MEMORIAL HOSPI BUFFALO TX 75831	1	0	0-100	1	100	1-97	.	.		.	.		10	0	0-49	3	0	0-87	.	.		9	0	0-58	3	0	0-100

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LEWISVILLE MEMORIAL HOSPIT LEWISVILLE TX 75067	TX-273	521	12	8-16	28	18	8-40	19	37	12-52	17	41	7-47	25	12	9-41	24	54	22-60	19	21	5-42	75	15	12-31
LILLIAN M HUOSPETH MEM HOS SONORA TX 76950	TX-274*	40	13	9-34	1	100	1-97	.	.		1	0	0-97	3	33	4-84	.	.		2	0	3-91	10	10	7-59
LINDEN MUNICIPAL HOSP LINDEN TX 75563	TX-275*	329	16	12-21	17	24	12-54	11	45	9-59	2	0	0-91	28	14	12-45	14	43	18-66	7	29	7-67	73	21	12-33
LITTLEFIELD MEDICAL CENTER LITTLEFIELD TX 79339	TX-276*	202	15	8-19	9	89	12-69	12	67	11-60	5	20	1-68	14	36	9-53	3	33	7-89	13	8	5-49	46	7	6-29
LLANO MEMORIAL HOSP LLANO TX 78643	TX-277	312	17	13-23	13	62	15-64	19	21	13-52	7	29	4-63	20	40	9-45	15	27	22-68	11	27	11-63	67	18	15-37
LOCKHART HOSPITAL LOCKHART TX 78644	TX-278*	258	16	8-18	10	40	6-58	3	0	3-83	6	33	2-64	10	40	7-58	3	100	6-87	16	19	5-45	40	20	10-36
LOCKNEY GENERAL HOSP LOCKNEY TX 79241	TX-279*	57	21	10-30	.	.		5	60	5-73	2	0	1-89	.	.		8	50	13-73	8	25	1-56	10	20	4-53
LUBBOCK GENERAL HOSP LUBBOCK TX 79417	TX-280	716	10	6-14	34	26	16-48	19	26	10-49	13	23	4-48	27	19	9-41	19	26	17-58	25	16	5-38	45	18	8-32
LUTHERAN GEN HOSP SAN ANTONIO TX 78285	TX-281	742	13	9-17	22	27	11-48	31	26	14-45	17	24	5-43	52	19	12-35	18	56	20-63	25	16	4-36	65	12	14-36
LYNN CO HOSP DISTRICT TAHOKA TX 79373	TX-282*	124	15	9-22		.		11	55	9-60	2	0	0-95	4	50	5-79	5	20	7-76	4	0	1-74	23	17	8-41
MADISON COUNTY HOSPITAL MADISONVILLE TX 77864	TX-283*	367	16	9-18	18	44	11-51	17	24	11-51	8	0	2-55	41	32	10-35	13	31	16-65	10	20	1-50	45	27	10-35
MAINLAND CENTER HOSPITAL TEXAS CITY TX 77592	TX-284	1077	13	9-16	52	25	18-45	38	34	16-45	25	24	5-36	47	13	11-35	44	27	23-52	17	18	5-44	104	35	14-31
MARION CO HOSP JEFFERSON TX 75657	TX-285*	153	14	7-19	8	38	11-71	5	20	5-72	5	20	0-70	4	0	2-75	7	57	14-76	4	25	4-77	16	19	4-41
MARKS-ENGLISH HOSP GLEN ROSE TX 76043	TX-286	138	9	8-21	2	100	2-90	4	0	6-80	7	14	1-59	8	38	5-61	3	0	6-87	2	50	1-89	28	11	6-36
MARSHALL MEMORIAL HOSPITAL MARSHALL TX 75670	TX-287*	971	16	9-17	63	40	16-41	48	48	18-44	23	26	7-41	77	25	14-34	42	36	23-52	25	24	5-38	55	24	12-36
MARTIN CO HOSP DIST STANTON TX 79782	TX-288*	65	15	8-27		.		2	100	4-92	1	0	0-98	3	33	3-83	5	40	11-82	1	0	0-98	15	20	5-46
MARY E DICKERSON MEM HOSP JASPER TX 75951	TX-289*	341	12	10-19	19	26	11-51	33	18	17-48	8	13	4-59	14	21	9-53	9	22	13-69	16	13	5-46	53	17	13-37
MARY SHIELS HOSP INC DALLAS TX 75204	TX-290*	43	0	0-30	2	0	0-91	.	.		.	.		.	.		.	.		.	.		.	.	
MASON MEMORIAL HOSP MASON TX 76856	TX-291*	28	36	10-40	1	100	3-99	2	100	1-89	.			1	0	0-99	.	.		1	0	0-99	15	33	10-53
MATAGORDA GENERAL HOSP BAY CITY TX 77414	TX-292	566	13	9-18	34	47	15-47	25	20	13-48	14	14	4-45	54	26	12-35	22	32	22-62	21	5	4-38	45	20	11-36
MAURITZ MEMORIAL HOSPITAL GANADO TX 77962	TX-293*	107	10	8-22	4	25	9-84	.	.		1	0	0-99	12	33	8-54	4	50	10-85	2	0	0-93	15	13	6-47
MAVERICK CO HOSP DISTRICT EAGLE PASS TX 78852	TX-294*	463	8	11-20	14	29	7-51	15	13	10-54	8	13	6-62	61	8	13-35	25	20	25-62	17	6	7-47	41	15	13-40
MCALLEN MEDICAL CENTER MCALLEN TX 78503	TX-295*	1983	12	8-15	101	33	15-35	53	25	15-39	54	15	8-31	88	17	14-32	68	38	24-48	80	19	8-29	173	25	14-28
MCCAMEY COUNTY HOSPITAL DI MCCAMEY TEXAS 79752	TX-296*	27	22	11-43	1	100	0-97	1	100	1-97	1	0	0-99	1	0	0-98	5	20	14-84	.	.		6	0	3-65
MCCUISTION REGIONAL MEDICA PARIS TX 75460	TX-297	1297	12	11-18	95	15	16-36	64	27	20-44	27	19	8-40	94	24	16-34	37	38	26-57	23	9	5-39	169	19	16-31
MCKENNA MEMORIAL HOSP NEW BRAUNFELS TX 78130	TX-298*	1145	14	8-15	89	22	13-34	40	38	16-45	29	10	6-35	49	20	13-38	44	41	26-55	24	17	5-38	87	29	12-30

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name, Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LEWISVILLE MEMORIAL HOSPIT LEWISVILLE TX 75067	2	50	1-90	3	67	5-85	17	0	1-33	2	0	0-100	55	4	1-14	23	9	0-30	4	0	0-100	40	5	1-17	39	0	0-24
LILLIAN M HUDSPETH MEM HOS SONORA TX 76950	2	50	1-90	.	.		.	.		.	.		6	0	2-62	2	50	0-91	.	.		3	0	0-94	.	.	
LINDEN MUNICIPAL HOSP LINDEN TX 75563	14	36	13-64	2	50	2-90	3	0	0-88	.	.		29	3	1-23	19	11	1-31	2	0	0-100	22	9	1-26	12	0	0-67
LITTLEFIELD MEDICAL CENTER LITTLEFIELD TX 79339	2	0	1-90	1	100	1-97	.	.		.	.		34	6	1-19	7	0	0-70	1	0	0-100	11	0	0-48	8	0	0-65
LLANO MEMORIAL HOSP LLANO TX 78643	4	50	7-83	4	75	7-83	15	7	1-37		.		27	0	1-24	12	17	2-43	.	.		17	0	0-33	9	0	0-83
LOCKHART HOSPITAL LOCKHART TX 78644	4	75	5-80	8	25	13-73	12	0	2-43	.	.		33	3	1-21	18	6	0-34	2	0	0-100	17	12	1-32	9	0	0-79
LOCKNEY GENERAL HOSP LOCKNEY TX 79241	3	0	2-83	2	50	3-92	1	0	0-100	.	.		6	0	0-70	.	.		.	.		5	0	0-80	.	.	
LUBBOCK GENERAL HOSP LUBBOCK TX 79417	13	15	4-52	11	55	14-68	17	12	2-35	42	0	0-31	48	13	2-18	8	13	0-64	5	0	0-100	58	9	1-14	77	0	0-11
LUTHERAN GEN HOSP SAN ANTONIO TX 78285	29	28	11-49	13	54	16-67	11	0	1-44	3	0	0-100	76	7	3-15	57	11	2-19	7	0	0-100	79	3	1-12	19	5	0-43
LYNN CO HOSP DISTRICT TAHOKA TX 79373	4	75	4-79	3	67	9-90	2	0	1-89	.	.		9	0	1-50	2	0	0-99	.	.		13	0	0-39	8	0	0-92
MADISON COUNTY HOSPITAL MADISONVILLE TX 77864	3	33	1-82	6	67	11-77	1	0	0-99	1	0	0-100	43	5	1-18	9	0	0-54	3	33	0-92	30	0	1-21	17	12	0-33
MAINLAND CENTER HOSPITAL TEXAS CITY TX 77592	10	30	7-62	20	45	22-65	29	7	2-26	9	0	0-100	112	9	3-13	53	0	1-17	14	0	0-99	105	4	2-11	79	3	0-10
MARION CO HOSP JEFFERSON TX 75657	.	.		2	0	3-91	1	0	0-99	.	.		22	9	1-27	7	14	0-64	.	.		11	9	1-44	3	0	0-100
MARKS-ENGLISH HOSP GLEN ROSE TX 76043	.	.		3	0	6-87	1	0	0-100	.	.		11	0	1-44	6	33	3-65	1	0	0-100	16	0	0-34	8	0	0-76
MARSHALL MEMORIAL HOSPITAL MARSHALL TX 75670	8	38	5-63	13	38	15-65	39	10	3-23	8	0	0-100	120	6	2-10	48	8	1-18	6	0	0-93	64	5	2-15	49	0	0-18
MARTIN CO HOSP DIST STANTON TX 79782	1	100	2-99	.	.		.	.		.	.		7	14	0-77	4	0	2-74	1	0	0-100	3	0	0-89	2	0	0-100
MARY E DICKERSON MEM HOSP JASPER TX 75951	1	0	0-97	3	33	5-86	2	0	0-92	1	0	0-100	30	7	1-22	59	3	0-16	3	0	0-100	18	0	0-31	8	0	0-95
MARY SHIELS HOSP INC DALLAS TX 75204	.	.		.	.		.	.		36	0	0-69	1	0	0-100	.	.		.	.		.	.		.	.	
MASON MEMORIAL HOSP MASON TX 76856	.	.		.	.		.	.		.	.		2	50	0-95	.	.		.	.		.			.	.	
MATAGORDA GENERAL HOSP BAY CITY TX 77414	4	50	7-83	2	50	3-92	11	0	2-46	1	0	0-100	66	0	1-13	28	4	1-25	8	0	0-100	50	8	2-16	11	0	0-81
MAURITZ MEMORIAL HOSPITAL GANADO TX 77962	1	0	0-97	2	0	3-92		.			.		14	0	1-37	3	33	0-86	.	.		16	0	1-34	1	0	0-100
MAVERICK CO HOSP DISTRICT EAGLE PASS TX 78852	9	0	3-58	9	33	20-78	6	0	1-62	1	0	0-100	51	6	3-19	34	3	1-21	6	0	0-87	46	0	1-17	9	0	0-83
MCALLEN MEDICAL CENTER MCALLEN TX 78503	24	21	5-44	29	38	26-63	46	9	4-24	9	0	0-100	256	4	2-8	70	9	1-15	21	0	0-97	323	3	2-7	80	1	0-9
MCCAMEY COUNTY HOSPITAL DI MCCAMEY TEXAS 79752	1	100	2-98	1	0	3-99	.	.		.	.		.	.		1	0	0-100	.	.					1	0	0-100
MCCUISTION REGIONAL MEDICA PARIS TX 75460	19	26	12-56	32	41	23-59	67	6	3-18	11	0	0-98	116	5	2-12	60	3	1-16	12	0	0-95	103	3	2-11	96	2	0-8
MCKENNA MEMORIAL HOSP NEW BRAUNFELS TX 78130	16	25	11-59	21	57	22-63	37	11	2-22	1	0	0-100	149	5	2-10	82	2	1-13	15	0	0-74	84	4	1-11	91	3	0-8

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MEDICAL ARTS HOSP LAMESA TX 79331	TX-299*	224	17	9-20	6	17	2-63	13	31	12-60	8	13	2-55	18	39	10-49	6	50	13-79	1	100	0-97	39	28	11-38
MEDICAL ARTS HOSP OF HOUST HOUSTON TX 77002	TX-300*	56	9	1-17	2	50	0-90	.	.		1	0	0-97	2	50	0-90	1	0	0-97	1	100	0-98	2	50	2-90
MEDICAL CENTER DEL ORO HOS HOUSTON TX 77054	TX-301*	418	10	6-14	29	34	11-43	21	5	11-47	8	0	2-56	10	30	5-54	8	38	10-68	12	42	10-59	18	17	7-44
MEDICAL CENTER HDSP DDESSA TX 79760	TX-302	2417	12	9-15	171	24	18-35	65	38	17-40	56	18	8-31	89	24	15-33	110	32	28-47	72	17	8-30	265	21	13-26
MEDICAL CENTER HOSP TYLER TX 75711	TX-303*	3029	12	9-15	259	17	17-33	128	34	20-37	64	27	9-31	117	29	17-33	114	44	31-50	43	19	11-39	174	33	16-31
MEDICAL CENTER HOSPITAL CONROE TX 77305	TX-304	1044	12	10-17	72	29	20-44	38	24	15-43	23	26	5-38	58	19	12-34	46	35	24-53	43	19	10-37	90	22	12-31
MEDICAL PLAZA HOSP FORT WORTH TX 76104	TX-305	1484	8	7-13	87	24	16-37	49	27	17-43	16	6	5-45	60	22	15-38	47	34	24-52	21	10	4-38	77	19	9-28
MEDICAL PLAZA HOSP SHERMAN TX 75090	TX-306	1006	11	10-17	64	20	17-41	36	17	17-47	28	25	8-39	71	18	13-33	48	35	23-51	20	30	11-50	92	18	12-30
MEDINA COMMUNITY HDSPITAL HONDO TX 78861	TX-307*	246	19	11-22	7	43	5-64	9	22	11-67	5	40	4-72	25	20	9-41	10	40	16-71	9	33	6-61	34	29	15-45
MEMDRIAL CITY MEDICAL CENT HOUSTON TX 77024	TX-308	1487	9	8-15	100	27	19-40	35	29	15-44	39	15	8-35	65	14	13-34	33	45	25-58	29	17	7-38	103	11	13-31
MEMDRIAL HDSP KERMIT TX 79745	TX-309*	180	14	7-19	5	40	6-75	7	43	6-65	3	33	4-84	11	18	9-59	9	44	14-71	10	20	4-54	21	43	9-45
MEMORIAL HDSP SEMINOLE TX 79360	TX-310*	110	6	5-17	1	0	0-97	1	0	2-98	.	.		7	14	6-65	3	33	4-84	2	0	1-89	13	15	5-48
MEMORIAL HOSP OF GARLAND GARLAND TX 75042	TX-311	996	15	10-17	65	18	14-37	47	32	19-46	33	24	6-33	49	22	12-35	52	38	25-52	23	17	6-40	99	20	12-30
MEMORIAL HOSPITAL CENTER TX 75935	TX-312*	362	14	10-20	7	57	8-70	16	38	17-62	8	25	6-63	29	17	10-40	22	36	20-60	15	20	4-44	70	17	11-31
MEMDRIAL HDSPITAL GONZALES TX 78629	TX-313*	240	17	10-21	13	54	11-59	12	33	12-61	1	0	0-99	15	27	7-48	15	40	17-63	7	0	3-62	39	26	10-37
MEMDRIAL HDSPITAL NACOGDOCHES TX 75961	TX-314*	1334	10	9-15	78	31	16-38	50	20	17-42	28	14	7-37	62	21	14-36	44	25	23-52	40	15	7-35	180	17	13-27
MEMDRIAL HDSPITAL REFUGIO TX 78377	TX-315*	113	15	8-22	4	75	3-76	4	50	7-81	1	0	1-98	13	15	6-49	3	33	8-89	10	30	4-53	18	17	8-46
MEMDRIAL HOSPITAL EL CAMPO EL CAMPO TX 77437	TX-316	367	16	9-18	17	18	8-49	18	22	13-54	8	50	6-62	23	39	8-40	14	57	17-64	12	33	5-51	32	34	11-40
MEMDRIAL HOSPITAL SYSTEM HOUSTON TX 77074	TX-317	4953	12	9-15	288	23	17-32	184	23	22-37	103	13	8-25	253	25	18-30	165	41	30-47	119	20	10-30	380	28	14-26
MEMDRIAL HOSPTIAL DUMAS TX 79029	TX-318	259	17	9-19	11	45	14-66	5	40	9-78	4	50	1-74	21	29	8-43	11	73	15-68	7	0	1-59	47	26	12-36
MEMDRIAL MEDICAL CENTER CORPUS CHRISTI TX 78405	TX-319*	1773	11	7-14	64	34	16-40	55	22	16-40	42	36	10-37	103	22	14-30	33	30	23-56	62	23	11-35	112	21	14-31
MEMDRIAL MEDICAL CENTER PORT LAVACA TX 77979	TX-320	289	15	9-18	10	40	4-54	7	29	5-64	7	0	3-62	29	17	9-39	13	69	18-68	14	29	6-50	53	13	8-30
MEMDRIAL MEDICAL CENTER OF LUFKIN TX 75901	TX-321	1792	14	10-17	127	23	18-37	74	23	19-41	35	11	11-41	93	30	16-34	73	36	31-54	37	14	11-40	173	25	15-29
MENARD HDSPITAL MENARD TX 76859	TX-322*	52	12	5-25	2	50	6-94	.	.		.	.		2	0	1-89	1	0	2-98	4	0	2-75	5	0	3-70
MERCY REGIONAL MEDICAL CEN LAREDO TX 78044	TX-323*	1835	12	9-16	70	36	18-42	43	23	17-44	39	21	10-37	177	23	16-30	57	33	26-52	55	31	12-38	148	26	16-32
MERIDIAN HDSPITAL MERIDIAN TEXAS 76665	TX-324*	41	7	6-28	1	0	0-97	3	0	2-81	2	D	0-92	1	0	0-97	1	0	1-97	2	0	1-89	5	0	1-68

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent*	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MEDICAL ARTS HOSP LAMESA TX 79331	3	33	2-83	5	20	7-77	4	0	0-78	.	.		44	5	1-17	13	23	2-42	1	0	0-100	17	0	1-32	9	0	0-66
MEDICAL ARTS HOSP OF HOUST HOUSTON TX 77002	1	0	0-100	.	.		.	.		.	.		6	0	0-85		.		1	0	0-100	2	0	0-99	8	0	0-97
MEDICAL CENTER DEL ORO HOS HOUSTON TX 77054	2	0	2-91	1	0	1-97	16	6	1-35	16	0	0-84	34	6	1-21	16	0	0-44	2	0	0-100	51	10	1-15	31	0	0-30
MEDICAL CENTER HOSP ODESSA TX 79760	25	24	12-52	16	31	18-64	65	11	3-19	56	0	0-27	224	3	3-10	125	2	2-12	4	0	0-95	280	4	2-7	112	1	0-7
MEDICAL CENTER HOSP TYLER TX 75711	43	23	9-41	23	61	24-64	155	7	4-15	6	0	0-100	305	5	3-9	208	5	1-10	20	0	0-70	167	3	2-9	287	0	0-4
MEDICAL CENTER HOSPITAL CONROE TX 77305	16	13	9-55	6	50	10-76	37	11	4-27	4	0	0-100	114	5	2-12	52	2	1-17	7	0	0-75	79	3	1-12	51	0	0-18
MEDICAL PLAZA HOSP FORT WORTH TX 76104	5	0	2-71	3	33	4-85	19	0	1-32	81	1	0-15	101	5	2-12	62	0	2-16	18	0	0-87	274	2	2-7	97	3	0-8
MEDICAL PLAZA HOSP SHERMAN TX 75090	9	33	8-66	13	0	14-63	24	4	2-29	.	.		74	8	2-14	77	3	1-14	3	0	0-100	142	4	2-10	41	0	0-17
MEDINA COMMUNITY HOSPITAL HONDO TX 78861	12	25	8-59	5	60	9-80	1	0	0-99	1	0	0-100	33	6	0-20	7	14	3-61	3	0	0-100	11	9	1-44	4	0	0-96
MEMORIAL CITY MEDICAL CENT HOUSTON TX 77024	11	18	11-65	19	16	16-59	32	13	3-26	15	0	0-98	130	4	3-12	99	2	1-13	23	0	0-96	186	5	2-9	100	2	0-8
MEMORIAL HOSP KERMIT TX 79745	2	50	3-91				2	0	0-99	.	.		19	0	0-30	4	0	0-87	1	0	0-100	21	5	1-27	17	0	0-71
MEMORIAL HOSP SEMINOLE TX 79360	3	0	0-83	2	50	2-90	.	.		.	.		15	0	0-36	1	0	0-99	.	.		9	0	0-56	5	0	0-99
MEMORIAL HOSP OF GARLAND GARLAND TX 75042	6	83	9-76	16	56	16-62	46	13	3-22	.	.		119	7	2-11	50	10	2-19	13	0	0-100	68	10	2-14	52	2	0-13
MEMORIAL HOSPITAL CENTER TX 75935	5	20	2-71	5	40	7-77	.	.		.			38	3	1-20	10	10	1-47	2	0	0-100	39	3	1-18	10	0	0-73
MEMORIAL HOSPITAL GONZALES TX 78629	3	0	1-82	3	67	4-84	5	20	0-69	1	0	0-100	26	0	1-25	9	11	0-51	3	0	0-100	19	5	1-29	3	0	0-99
MEMORIAL HOSPITAL NACOGDOCHES TX 75961	19	37	12-56	8	25	7-65	47	2	3-22	5	20	0-100	135	5	2-10	52	4	2-18	6	0	0-100	125	2	2-10	97	0	0-8
MEMORIAL HOSPITAL REFUGIO TX 78377	1	100	2-98	.			.	.			.		4	0	0-82	7	14	0-65	2	0	0-100	9	0	0-53	4	0	0-100
MEMORIAL HOSPITAL EL CAMPO EL CAMPO TX 77437	7	14	4-66	5	60	9-80	10	10	1-47	.	.		43	9	2-19	19	5	1-31	5	0	0-100	38	5	1-18	5	0	0-100
MEMORIAL HOSPITAL SYSTEM HOUSTON TX 77074	66	27	10-40	53	38	26-55	113	9	4-17	45	2	0-26	459	7	3-8	287	5	2-10	43	0	0-32	467	6	3-7	253	1	0-5
MEMORIAL HOSPITAL DUMAS TX 79029	4	50	3-77				2	0	0-90	.	.		38	3	1-18	3	33	0-82	.	.		27	4	1-23	2	50	0-100
MEMORIAL MEDICAL CENTER CORPUS CHRISTI TX 78405	26	23	7-45	8	50	13-73	24	13	2-29	39	0	0-45	161	5	3-11	73	7	1-14	11	0	0-98	188	3	2-9	74	3	0-10
MEMORIAL MEDICAL CENTER PORT LAVACA TX 77979	5	0	2-71	3	33	4-85	5	20	0-72	.	.		32	3	1-20	10	20	1-47	1	0	0-100	23	0	1-26	6	0	0-93
MEMORIAL MEDICAL CENTER OF LUFKIN TX 75901	31	19	10-46	16	44	19-65	51	10	3-21	1	0	0-100	173	7	2-10	71	10	2-16	12	0	0-100	221	2	3-10	96	4	0-8
MENARD HOSPITAL MENARD TX 76859	2	50	1-90	1	100	1-97	3	33	1-81	.	.		3	0	0-96	.	.		.	.		5	0	0-77	6	0	0-98
MERCY REGIONAL MEDICAL CEN LAREDO TX 78044	20	40	10-52	25	40	19-58	44	9	4-24	5	0	0-100	294	2	3-9	89	3	1-13	25	0	0-51	108	5	2-11	84	4	0-9
MERIDIAN HOSPITAL MERIDIAN TEXAS 76655	1	0	0-97	3	67	7-88	1	0	0-100	.	.		3	0	0-93	.	.		1	0	0-100	4	0	0-88	2	0	0-97

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MERIOIAN HOSPITAL MERIOIAN TX 76665	TX-325*	28	14	5-33	2	50	1-89	5	20	5-72	1	0	0-100	2	0	1-89	1	0	0-97	.	.		5	20	2-69
MESQUITE COMMUNITY HOSP MESQUITE TX 75150	TX-326	490	14	8-16	18	44	9-48	13	38	12-59	10	30	2-51	23	26	9-43	21	48	21-62	10	10	4-54	86	21	11-29
MESQUITE PHYSICIANS HOSP MESQUITE TX 75149	TX-327	324	31	11-21	1	100	0-98	9	44	10-65	5	80	2-69	22	55	12-48	5	60	11-81	15	60	4-44	89	37	14-33
METHOOIST HOSPITAL LUBBOCK TX 79410	TX-328	4204	10	8-14	333	22	18-33	130	25	21-38	75	19	9-30	163	29	17-31	129	36	29-48	73	18	11-34	249	17	13-25
METHOOIST MEOICAL CENTER OALLAS TX 75208	TX-329	2692	13	9-15	181	19	16-33	88	34	20-40	47	30	10-35	112	28	16-33	103	42	29-49	99	30	10-30	161	28	13-27
METROPLEX HOSP KILLEEN TX 76542	TX-330	372	19	11-20	21	14	11-49	8	38	7-64	7	14	5-65	31	42	13-43	25	48	25-63	11	27	4-52	49	24	10-34
METROPOLITAN HOSPITAL CORP OALLAS TX 75227	TX-331	245	16	9-19	6	50	3-65	8	38	8-65	9	22	5-57	22	27	12-48	7	43	12-75	5	20	3-70	22	14	7-40
MIO JEFFERSON COUNTY HOSP NEOERLANO TX 77627	TX-332	680	16	10-17	36	19	12-41	29	34	15-48	28	21	9-41	32	44	11-41	21	48	24-64	33	30	8-37	71	24	12-32
MIOLANO MEMORIAL HOSP MIOLANO TX 79701	TX-333	1369	14	9-16	105	35	17-38	37	41	17-46	28	25	5-35	66	20	15-36	45	29	26-55	50	28	12-39	101	32	13-30
MILAM REGIONAL MEOICAL CTR CAMERON TX 76520	TX-334	108	12	7-22	4	25	4-77	2	0	1-89	3	0	1-81	8	25	6-62	5	80	8-77	5	0	2-69	13	15	4-46
MINEOLA GEN HOSPITAL INC MINEOLA TX 75773	TX-335*	71	21	6-23	1	0	0-98	3	33	5-85	1	0	0-98	7	71	6-65	3	100	5-86	3	33	1-82	14	7	3-42
MINEOLA GENERAL HOSPITAL I MINEOLA TX 76773	TX-336*	8	25	2-55	1	100	2-98	.	.		.	.		.	.		.	.		.	.		1	0	0-100
MISSION HOSPITAL INC MISSION TX 78572	TX-337*	546	15	9-17	28	25	11-45	19	42	12-51	8	25	3-57	20	25	11-48	21	62	20-60	25	16	5-38	78	19	12-31
MITCHELL COUNTY HOSPITAL COLORADO CITY TX 79512	TX-338*	234	15	8-19	7	0	4-63	7	57	8-69	4	25	1-74	19	26	9-47	9	44	14-71	17	12	4-42	41	20	9-34
MOTHER FRANCES HOSP TYLER TX 75701	TX-339	2515	11	8-14	158	22	16-33	82	34	17-37	45	11	5-29	118	18	15-31	143	38	28-46	41	29	11-39	153	20	12-27
MUENSTER MEMORIAL HOSP MUENSTER TX 76252	TX-340*	117	13	6-19	6	17	2-64	3	33	3-83	1	0	0-100	8	50	4-59	3	0	3-83	2	0	2-90	16	25	8-48
NACOGOOCHES MEOICAL CTR HO NACOGOOCHES TX 75963	TX-341	906	13	9-17	67	21	15-39	35	29	15-45	16	19	6-45	59	31	15-37	27	37	22-58	40	18	7-34	109	28	13-30
NAN TRAVIS MEMORIAL HOSP JACKSONVILLE TX 75766	TX-342*	1449	11	10-17	61	25	17-41	71	21	19-42	14	14	6-49	103	17	15-32	56	29	27-53	38	21	10-38	161	16	12-27
NAVARRO REGIONAL HOSPITAL CORSICANA TX 75110	TX-343	1634	12	9-16	130	30	16-35	67	33	20-42	44	11	9-35	51	14	12-35	74	35	27-50	31	6	5-35	131	21	13-28
NAVASOTA REGIONAL HOSPITAL NAVASOTA TX 77868	TX-344*	396	17	12-22	25	40	15-52	27	22	13-46	9	11	3-55	46	20	14-40	18	22	17-60	22	18	8-44	58	21	10-32
NEW BOSTON GENERAL HOSP NEW BOSTON TX 75570	TX-345*	113	24	9-24	2	50	1-89	7	43	9-70	3	33	1-81	11	18	9-59	5	60	14-85	7	29	3-61	19	32	6-43
NEWTON CO MEM HOSP NEWTON TX 75966	TX-346*	127	15	8-21	3	33	2-82	7	14	8-69	1	0	0-100	7	14	4-63	7	57	11-74	8	38	3-57	20	15	8-45
NIX MEOICAL CENTER SAN ANTONIO TX 78205	TX-347	1579	12	9-15	168	34	16-33	63	27	19-42	51	10	10-35	71	27	14-35	55	35	26-53	33	15	8-38	68	13	11-32
NOCONA GENERAL HOSP NOCONA TX 76255	TX-348*	156	22	10-24	8	63	12-72	8	50	10-69	5	0	2-69	8	38	5-61	9	56	14-71	5	20	3-70	21	29	10-46
NORTH RUNNELS HOSP WINTERS TX 79567	TX-349*	109	17	10-25	3	0	2-82	7	57	7-67	8	25	3-57	4	25	3-76	10	50	20-75	2	50	0-90	21	19	5-38
NORTH TEXAS MEOICAL CENTER MCKINNEY TX 75069	TX-350	659	17	10-18	22	18	9-45	21	38	13-51	18	17	5-42	57	19	14-36	50	52	27-55	27	33	8-40	66	41	13-34

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MERIDIAN HOSPITAL MERIDIAN TX 76665	.	.		.	.		2	0	0-91	.	.		1	0	0-100	1	0	0-100	.	.		2	50	0-99	2	0	0-100
MESQUITE COMMUNITY HDSP MESQUITE TX 75150	2	0	2-90	1	0	0-97	13	0	3-44	.	.		52	8	1-15	30	3	1-24	8	0	0-100	38	0	1-17	36	0	0-21
MESQUITE PHYSICIANS HDSP MESQUITE TX 75149	10	50	7-62	12	67	13-64	6	17	0-70	.	.		30	17	2-24	27	19	2-27	2	0	0-100	15	7	1-35	5	0	0-100
METHODIST HOSPITAL LUBBOCK TX 79410	40	10	9-42	21	62	24-66	151	10	6-17	42	0	0-28	451	3	3-9	208	4	2-11	48	0	0-49	613	4	3-7	372	2	1-4
METHODIST MEDICAL CENTER DALLAS TX 75208	86	8	3-32	17	47	18-64	102	12	3-16	7	0	0-100	239	5	3-10	101	6	1-13	23	0	0-54	296	5	3-8	159	0	0-6
METROPLEX HOSP KILLEEN TX 76542	5	80	7-78	10	60	14-69	10	10	2-48	1	0	0-100	48	6	2-17	9	22	0-51	3	0	0-100	33	3	1-21	13	0	0-53
METROPOLITAN HOSPITAL CORP DALLAS TX 75227	4	25	1-76	6	67	8-74	21	5	3-33	.	.		19	5	1-30	23	22	5-35	7	0	0-100	18	6	1-31	7	0	0-94
MID JEFFERSON COUNTY HOSP NEDERLAND TX 77627	13	23	10-61	6	50	11-77	19	16	1-32	2	0	0-100	76	1	2-13	40	10	2-21	6	0	0-98	62	6	1-14	23	4	0-31
MIDLAND MEMORIAL HDSP MIDLAND TX 79701	7	14	5-68	12	42	17-69	56	4	3-20	3	0	0-100	168	8	3-11	91	1	1-13	15	7	0-78	87	7	2-12	115	0	0-7
MILAM REGIONAL MEDICAL CTR CAMERON TX 76520	6	33	5-71	.	.		.	.		.	.		8	0	0-62	3	0	1-81	.	.		19	0	0-30	2	0	0-100
MINEOLA GEN HOSPITAL INC MINEOLA TX 75773	1	100	1-97	.	.		1	0	0-99	.	.		7	14	0-66	1	0	0-100	.	.		6	17	0-71	5	0	0-99
MINEOLA GENERAL HOSPITAL I MINEOLA TX 76773	1	0	1-97	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
MISSION HOSPITAL INC MISSION TX 78572	2	100	6-95	12	50	15-66	24	17	2-29	1	0	0-100	73	7	2-13	23	9	0-28	3	0	0-100	42	10	1-17	28	4	0-31
MITCHELL COUNTY HOSPITAL COLORADO CITY TX 79512	1	0	0-99	1	0	1-97	4	50	1-74	.	.		26	8	0-24	12	8	2-43	.	.		23	0	1-26	5	0	0-100
MOTHER FRANCES HOSP TYLER TX 75701	20	15	8-50	14	29	16-64	56	16	3-20	49	0	0-41	321	6	3-9	76	8	1-14	47	0	0-67	443	5	2-7	89	0	0-9
MUENSTER MEMORIAL HOSP MUENSTER TX 76252	2	50	1-90	1	0	3-99	4	25	0-77	.	.		18	0	0-32	4	25	0-92	2	0	0-100	5	0	0-75	14	0	0-79
NACOGDOCHES MEDICAL CTR HO NACOGDOCHES TX 75963	11	55	6-59	4	25	12-88	15	13	2-39	3	0	0-100	89	3	2-12	90	4	1-13	24	0	0-76	79	3	1-11	29	3	0-25
NAN TRAVIS MEMORIAL HDSP JACKSONVILLE TX 75766	20	30	11-54	32	28	24-59	31	3	2-24	6	0	0-98	179	6	2-10	111	5	3-15	12	0	0-99	140	4	2-10	49	0	0-15
NAVARRO REGIONAL HOSPITAL CORSICANA TX 75110	24	8	8-47	20	45	21-64	69	4	4-19	7	0	0-81	149	6	3-11	147	6	2-12	11	0	0-99	149	7	2-10	70	0	0-10
NAVASOTA REGIONAL HOSPITAL NAVASOTA TX 77868	2	0	1-90	13	69	20-71	7	0	1-57				28	11	1-24	19	5	1-31	2	0	0-100	39	5	1-18	7	0	0-86
NEW BOSTON GENERAL HOSP NEW BOSTON TX 75570	1	0	0-97	1	0	1-97	1	0	0-99	.	.		9	0	0-60	2	0	0-97	.	.		8	13	0-63	8	0	0-91
NEWTON CO MEM HOSP NEWTON TX 75966	1	0	0-97	2	100	1-89	.	.		.			12	0	0-47	2	0	0-97	1	0	0-100	10	10	0-49	3	0	0-100
NIX MEDICAL CENTER SAN ANTONIO TX 78205	8	25	10-71	22	32	20-61	39	8	2-22	46	0	0-30	156	6	3-11	75	3	1-14	12	0	0-99	144	6	2-10	139	3	0-6
NOCONA GENERAL HOSP NOCONA TX 76255	2	50	4-93	1	0	0-97	.	.		.	.		10	0	0-52	8	0	0-56	.	.		17	0	0-32	6	0	0-69
NORTH RUNNELS HOSP WINTERS TX 79567	2	0	0-90	.	.		.	.		.	.		19	0	1-31	1	0	0-97	1	0	0-100	2	0	0-99	2	0	0-100
NORTH TEXAS MEDICAL CENTER MCKINNEY TX 75069	8	63	8-68	11	18	16-69	28	11	2-27	.	.		69	6	2-14	44	9	1-18	12	0	0-99	51	2	1-16	43	0	0-17

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
NORTHEAST MEDICAL CENTER H HUMBLE TX 77338	TX-351	1277	10	8-15	56	38	17-43	28	29	14-48	34	18	6-33	89	20	14-32	39	56	24-55	43	7	6-31	151	12	12-26
NORTHPARK HOSPITAL EL PASO TX 79904	TX-352*	104	7	3-15	3	67	0-82	1	0	2-98	1	0	0-99	4	0	2-74	.	.		4	0	0-76	10	0	3-50
NORTHWEST TEXAS HOSP AMARILLO TX 79175	TX-353*	1573	10	7-14	98	14	11-30	65	38	17-40	38	13	6-31	59	17	12-33	63	2	24-49	30	23	7-37	123	15	12-28
OAK CLIFF MEDICAL SURGIC DALLAS TX 75208	TX-354	475	10	8-16	26	8	7-40	13	15	9-55	10	10	3-51	20	35	9-45	27	48	25-61	21	19	6-42	48	17	9-32
OCHILTREE GENERAL HOSP PERRYTON TX 79070	TX-355*	153	14	7-19	4	75	2-75	4	75	6-80	2	50	1-89	6	33	3-64	6	83	17-84	8	0	5-61	31	13	6-33
ODESSA WOMENS CHILORENS HO ODESSA TX 79760	TX-356	159	5	7-18	10	0	5-55	1	0	1-98	2	0	1-89	5	0	4-72	3	0	5-86	3	0	1-82	50	6	7-29
OMNI HOSPITAL & MEDICAL CE HOUSTON TX 77028	TX-357	109	12	5-19	1	0	1-97	7	14	7-67	1	0	0-100	5	0	2-68	5	60	14-85	2	0	0-92	17	29	4-41
ORANGE MEMORIAL HOSPITAL ORANGE TX 77630	TX-358	759	14	9-16	26	8	10-44	21	38	15-53	24	17	5-37	68	18	14-35	23	48	22-60	38	26	10-38	74	19	12-32
OTTO KAISER MEM HOSP KENEDY TX 78119	TX-359*	174	20	8-19	1	100	1-97	5	40	7-76	3	33	0-83	15	7	7-48	8	25	10-69	5	40	1-68	33	33	10-39
OVERALL-MORRIS MEM HOSP COLEMAN TX 76834	TX-360*	230	17	11-22	6	33	9-74	18	33	12-53	4	0	2-75	11	18	7-55	18	39	21-64	3	0	1-82	41	34	11-37
OVERTON MEDICAL CENTER OVERTON TX 75684	TX-361*	42	12	4-25	1	0	2-98	1	0	1-97	1	0	0-97	1	0	1-97	.	.		1	0	0-98	8	25	2-56
PALO OURO HOSP CANYON TX 79015	TX-362*	197	9	5-15	4	25	4-77	8	38	8-65	.	.		11	9	5-53	2	0	4-92	4	0	2-75	23	30	6-37
PALO PINTO GEN HOSP MINERAL WELLS TX 76067	TX-363*	785	14	10-18	35	43	13-44	22	32	14-52	27	15	7-38	37	22	11-38	54	35	28-55	21	5	5-40	107	22	12-29
PANOLA GEN HOSP CARTHAGE TX 75633	TX-364*	422	20	10-19	18	72	12-54	38	29	17-46	8	0	3-57	38	42	11-38	11	64	14-67	16	19	5-46	53	25	10-33
PARK PLACE HOSP PORT ARTHUR TX 77642	TX-365	1136	12	8-15	64	31	19-43	28	36	14-47	21	10	5-39	59	19	14-37	31	48	26-60	25	24	7-41	101	14	10-26
PARKLAND MEMORIAL HOSPITAL DALLAS TX 75235	TX-366	2133	13	8-14	152	18	17-34	94	28	16-35	43	30	9-35	108	13	12-28	62	32	24-48	88	16	7-27	174	23	10-24
PARKVIEW HOSP WHEELER TX 79096	TX-3678	158	8	9-21	3	67	7-88	7	29	11-73	3	0	2-82	13	8	8-53	1	100	1-97	5	0	3-71	30	10	10-41
PARMER COUNTY COMMUNITY HO FRIONA TX 79035	TX-368*	84	26	9-26	.	.		3	67	4-84	1	100	0-99	5	20	4-71	3	67	9-91	7	43	4-63	17	47	9-49
PASADENA GENERAL HOSP PASADENA TX 77506	TX-369	230	10	7-17	12	17	7-55	7	14	6-66	10	30	4-54	14	7	6-49	11	27	16-69	2	0	0-94	15	20	5-46
PECOS CO MEM HOSP FORT STOCKTON TX 79735	TX-370*	191	15	8-20	2	50	1-89	2	0	1-89	8	50	4-59	11	18	6-54	8	13	12-71	9	11	4-56	32	25	9-37
PERMIAN GENERAL HOSP ANDREWS TX 79714	TX-371*	332	11	6-15	18	28	8-47	5	40	5-72	9	11	2-53	11	0	5-52	10	100	17-72	9	0	2-53	60	13	8-28
PHYSICIANS AND SURGEONS HO MIDLAND TX 79705	TX-372	310	5	4-13	13	15	4-47	1	0	1-97	4	0	0-77	17	0	6-43	8	25	10-69	3	67	1-82	14	0	4-45
PIONEER PARK MEDICAL CENTE IRVING TX 75061	TX-373*	74	7	3-18	3	33	1-81	.	.		3	33	1-81	4	25	1-73	1	0	0-97	1	0	0-100	4	25	0-76
PITTSBURG MEDICAL CENTER PITTSBURG TX 75686	TX-374*	276	16	11-21	8	50	18-79	6	50	10-75	6	0	1-63	19	26	9-46	13	31	15-64	16	13	2-40	44	20	10-35
PLAINS MEMORIAL HOSP DIMMITT TX 79027	TX-375*	82	18	7-23	2	50	4-92	3	33	3-83	4	25	1-74	5	40	2-68	6	50	11-77	5	20	2-69	10	30	4-52
POLLY RYON MEM HOSP RICHMOND TX 77469	TX-376	734	17	9-17	41	24	11-39	28	54	13-46	16	31	4-43	50	28	13-37	31	45	24-58	19	26	8-46	76	22	11-31

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
Name/ Location	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
NORTHEAST MEDICAL CENTER H HUMBLE TX 77338	10	20	4-57	12	42	14-66	25	4	1-26	3	0	0-100	118	2	2-11	67	4	2-16	7	0	0-99	161	4	2-9	53	0	0-15
NORTHPARK HOSPITAL EL PASO TX 79904	1	0	2-98	.	.		.	.		.	.		10	0	0-55	8	25	0-61	.	.		11	0	0-51	4	0	0-99
NORTHWEST TEXAS HOSP AMARILLO TX 79175	12	0	5-55	14	36	16-65	60	8	3-19	6	0	0-100	178	7	3-10	90	2	1-13	29	0	0-90	99	1	2-11	92	4	0-9
OAK CLIFF MEDICAL SURGIC DALLAS TX 75208	5	60	3-73	3	33	3-84	8	0	1-54	.	.		34	3	1-20	46	0	0-19	5	0	0-100	55	4	1-15	28	0	0-31
OCHILTREE GENERAL HOSP PERRYTON TX 79070	1	0	0-100	.	.		.	.		.	.		13	15	0-41	11	0	0-45	.	.		19	0	0-29	3	0	0-100
ODESSA WOMENS CHILDRENS HO ODESSA TX 79760	3	67	2-82	2	50	3-91	.	.		.	.		6	0	0-79	2	0	1-89	16	0	0-99	14	0	0-37	3	0	0-100
OMNI HOSPITAL & MEDICAL CE HOUSTON TX 77028	3	33	0-83	1	100	1-97	2	0	0-96	1	0	0-100	8	0	0-66	10	0	0-56	1	0	0-100	7	0	0-76	7	0	0-88
ORANGE MEMORIAL HOSPITAL ORANGE TX 77630	12	33	5-55	13	54	14-64	14	21	2-40	.	.		104	6	2-11	57	9	1-16	10	0	0-100	47	13	1-17	36	3	0-30
OTTO KAISER MEM HOSP KENEDY TX 78119	1	100	0-97	1	0	1-97	6	0	0-66	.	.		21	5	1-28	10	10	1-47	.	.		19	16	1-29	4	0	0-90
OVERALL-MORRIS MEM HOSP COLEMAN TX 76834	4	0	2-76	3	33	7-89	6	0	1-62	1	0	0-100	23	17	1-26	16	6	1-35	1	0	0-100	11	0	0-49	11	0	0-76
OVERTON MEDICAL CENTER OVERTON TX 75684	.	.		.	.		.	.		.	.		8	0	0-70	1	0	0-100	.	.		2	100	2-90	1	0	0-100
PALO DURO HOSP CANYON TX 79015	2	0	0-94	.	.		2	0	0-98	.	.		34	6	1-19	7	0	0-61	2	0	0-100	21	0	0-28	3	0	0-100
PALO PINTO GEN HOSP MINERAL WELLS TX 76067	7	29	8-71	7	57	13-76	36	8	4-26	.	.		76	3	2-14	45	9	1-19	8	0	0-100	68	6	1-13	36	0	0-18
PANOLA GEN HOSP CARTHAGE TX 75633	9	33	6-63	1	0	1-97	15	7	1-36	.	.		57	11	1-15	10	0	1-47	2	0	0-100	28	14	1-24	9	0	0-95
PARK PLACE HOSP PORT ARTHUR TX 77642	18	39	8-52	17	59	23-69	20	5	1-31	1	0	0-100	118	3	2-11	89	3	1-13	13	8	0-87	99	6	2-12	51	2	0-13
PARKLAND MEMORIAL HOSPITAL DALLAS TX 75235	43	9	3-36	18	72	14-57	59	22	3-20	20	0	0-84	153	6	3-11	101	17	2-13	20	5	0-96	204	4	3-9	83	1	0-9
PARKVIEW HOSP WHEELER TX 79096	3	0	2-83	1	100	2-98	.	.		.	.		6	0	0-69	5	0	0-70	.	.		26	0	1-23	3	0	0-100
PARMER COUNTY COMMUNITY HO FRIONA TX 79035	3	33	5-87	.	.		.	.		.	.		11	9	1-44	.	.		.	.		12	0	0-41	2	50	0-95
PASADENA GENERAL HOSP PASADENA TX 77506	2	100	3-91	3	33	3-84	6	17	1-62	.	.		32	9	1-20	14	0	0-43	.	.		23	4	1-26	11	0	0-77
PECOS CO MEM HOSP FORT STOCKTON TX 79735	9	11	7-64	.	.		.	.		1	0	0-100	45	2	2-18	5	0	1-68	1	0	0-100	6	17	0-78	6	0	0-84
PERMIAN GENERAL HOSP ANDREWS TX 79714	2	50	1-90	2	50	4-92	11	0	0-45	.	.		61	2	1-13	9	22	0-52	5	0	0-100	33	9	1-20	15	0	0-57
PHYSICIANS AND SURGEONS HO MIDLAND TX 79705	1	0	0-97	2	50	6-95	7	0	1-57	.	.		29	3	1-22	12	8	0-66	2	0	0-100	101	5	1-10	20	0	0-53
PIONEER PARK MEDICAL CENTE IRVING TX 75061	1	0	3-100	1	100	2-98	1	0	0-100	.	.		21	0	0-29	5	0	0-86	3	0	0-100	2	0	0-98	2	0	0-100
PITTSBURG MEDICAL CENTER PITTSBURG TX 75686	7	29	2-63	18	61	22-66	1	0	0-100	.	.		35	6	0-19	16	6	1-35	2	0	0-100	26	0	1-23	6	0	0-91
PLAINS MEMORIAL HOSP DIMMITT TX 79027	.	.		2	50	2-90	.	.		.	.		11	0	0-44	3	0	0-87	2	0	0-100	7	0	0-70	2	0	0-100
POLLY RYON MEM HOSP RICHMOND TX 77469	9	44	13-72	17	29	15-59	18	17	2-34	.	.		83	2	1-11	38	8	1-20	8	0	0-98	64	13	1-13	33	6	0-19

.*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
PRESBYTERIAN HDSP DALLAS TX 75231	TX-377	4406	9	7-13	337	15	15-30	126	25	19-36	88	14	10-29	139	18	16-31	153	32	29-46	52	13	10-36	238	21	15-28
PRESBYTERIAN HOSP OF WINNS WINNSBORO TX 75494	TX-378	285	18	11-21	19	37	11-50	10	20	9-62	11	9	3-49	17	24	9-49	19	58	24-67	12	17	3-48	40	30	12-39
PRESBYTERIAN HOSPITAL OF K KAUFMAN TX 75142	TX-379*	674	13	10-18	33	27	16-49	27	26	13-47	16	19	6-45	42	12	11-36	36	53	23-55	22	18	5-39	106	18	12-29
PROVIDENCE HOSP WACO TX 76702	TX-380	1877	13	8-15	120	21	15-33	71	34	19-40	36	31	11-39	81	21	14-33	72	44	29-53	49	22	8-34	114	23	12-28
PROVIDENCE MEM HOSP EL PASO TX 79902	TX-381	2380	10	7-14	147	27	17-35	62	35	20-44	40	15	6-31	86	14	13-31	61	39	25-51	44	30	7-34	173	23	14-28
QUANAH MEDICAL CENTER QUANAH TX 79252	TX-382*	148	18	11-25	9	44	16-74	8	63	9-67	2	0	0-94	7	29	6-65	8	63	16-76	1	0	0-99	28	14	11-43
R E THOMASON GEN HOSP EL PASO TX 79905	TX-383	525	14	6-14	24	38	11-47	13	54	9-55	6	33	1-63	16	6	7-46	25	56	24-62	9	33	3-55	41	22	8-33
RALEIGH HILLS GENERAL HOSP HOUSTON TX 77087	TX-384*	1	0	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
RANGER GENERAL HOSPITAL RANGER TX 76470	TX-385	165	16	8-20	1	0	0-98	4	75	7-81	4	25	1-74	14	0	7-50	9	89	14-71	4	0	2-74	29	21	9-39
REAGAN MEM HOSP BIG LAKE TX 76932	TX-386	26	12	4-33	.	.		5	40	4-71	.			.	.		1	100	0-97	2	0	1-89	9	0	2-51
RED RIVER GEN HOSP CLARKSVILLE TX 75426	TX-387*	454	12	11-20	8	50	10-69	24	29	15-51	9	11	2-52	31	23	13-43	32	34	25-58	17	18	7-47	57	9	12-34
REEVES COUNTY HOSP PECOS TX 79772	TX-388*	121	14	7-20	7	57	7-68	7	14	8-68	3	0	0-84	1	0	0-97	2	50	2-90	4	0	0-79	12	17	5-50
RICHARDS MEMORIAL HOSPITAL ROCKDALE TX 76567	TX-389*	278	17	11-22	8	38	15-75	18	33	13-54	4	50	4-77	12	17	8-54	14	50	18-66	15	13	7-50	37	41	14-43
RICHARDSON MEDICAL CENTER RICHARDSON TX 75080	TX-390	578	14	8-16	47	21	12-39	22	27	14-52	8	13	2-56	30	17	13-44	12	33	18-69	19	16	4-41	73	29	11-31
RIVERSIDE GEN HOSP HOUSTON TX 77004	TX-391*	57	19	5-23	.	.		2	0	1-89	.	.		5	40	2-69	1	100	1-97	3	33	2-81	8	63	6-62
ROBERT H DEDMAN MEM MED CT DALLAS TX 75381	TX-392	808	15	9-17	43	37	18-47	37	16	14-42	13	38	4-48	38	29	12-39	48	35	27-55	25	24	7-40	75	28	11-30
ROLLING PLAINS MEMORIAL HD SWEETWATER TX 79556	TX-393*	557	13	11-19	14	21	11-56	18	22	17-59	8	25	3-57	40	38	12-39	27	41	22-59	29	21	7-38	98	22	12-30
ROLLINS BROOK HOSP LAMPASAS TX 76550	TX-394*	251	14	9-20	13	8	6-51	9	33	8-62	12	50	6-53	14	14	8-52	16	31	21-66	13	23	4-48	34	26	9-38
ROSEBUD COMMUNITY HOSPITAL ROSEBUD TX 76570	TX-395*	228	16	10-22	4	50	9-84	12	25	11-60	6	0	2-64	17	18	10-50	13	46	18-68	12	25	5-51	35	29	10-38
ROSEWOOD MEDICAL CENTER HOUSTON TX 77063	TX-396	729	16	9-17	34	24	9-38	71	21	17-38	12	25	2-45	30	33	11-41	22	41	19-59	6	17	2-65	71	32	13-34
ROUND ROCK COMMUNITY HOSPI ROUND ROCK TX 78681	TX-397	329	10	8-17	29	28	13-47	8	25	6-63	19	5	4-39	11	18	8-56	16	44	17-62	5	0	1-68	28	14	6-36
ROY H LAIRD MEM HOSP KILGORE TX 75662	TX-398*	446	17	10-19	14	29	10-55	18	39	13-53	10	30	5-55	31	35	12-42	19	37	20-62	17	29	9-51	55	25	13-36
SABINE COUNTY HOSPITAL HEMPHILL TX 75948	TX-399	226	18	10-22	5	80	14-85	19	47	14-54	6	0	1-63	15	20	7-48	19	32	18-60	4	0	2-74	51	14	8-31
SAINT JOSEPH HOSP FORT WORTH TX 76104	TX-400	2846	14	8-15	216	20	15-31	118	30	20-38	92	23	9-28	144	20	15-29	75	49	26-49	78	19	9-30	192	26	13-27
SAM HOUSTON MEM HOSP HOUSTON TX 77055	TX-401*	483	10	8-16	27	11	8-40	12	17	9-57	9	22	5-57	24	17	11-45	14	21	17-64	17	6	5-43	52	13	8-29
SAN ANTONIO STATE CHEST HD SAN ANTONIO TEXAS 78223	TX-402	186	9	7-18	14	14	8-52	3	33	2-81	3	0	1-81	6	33	3-65	1	0	1-98	1	0	0-97	57	7	8-28

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
PRESBYTERIAN HOSP DALLAS TX 75231	31	39	11-48	29	41	20-57	137	8	4-15	380	0	0-2	358	5	3-8	181	4	1-10	67	0	0-33	366	7	3-8	325	2	0-4
PRESBYTERIAN HOSP OF WINNS WINNSBORO TX 75494	1	0	1-97	5	20	11-82	1	0	0-97	.	.		25	4	1-25	28	14	1-25	3	0	0-100	18	6	0-32	9	11	0-77
PRESBYTERIAN HOSPITAL OF K KAUFMAN TX 75142	13	38	10-60	3	33	5-85	16	6	2-37	2	0	0-100	82	7	2-13	15	7	1-36	5	0	0-100	110	0	2-11	11	0	0-84
PROVIDENCE HOSP WACO TX 76702	11	36	8-61	16	38	16-62	45	7	3-22	1	0	0-100	185	9	3-11	80	8	2-15	16	0	0-93	334	5	2-7	48	0	0-15
PROVIDENCE MEM HOSP EL PASO TX 79902	15	7	3-48	37	38	18-51	59	8	3-19	13	0	0-91	245	3	2-9	143	3	1-12	26	4	0-30	148	3	2-10	215	2	0-5
QUANAH MEDICAL CENTER QUANAH TX 79252	3	0	2-83	.	.		4	0	0-77	.	.		16	6	2-35	2	0	0-99	.	.		10	0	1-46	5	0	0-84
R E THOMASON GEN HOSP EL PASO TX 79905	2	0	0-94	4	25	4-77	24	13	2-30	.	.		43	14	1-18	35	6	0-22	4	0	0-100	20	5	0-28	24	0	0-44
RALEIGH HILLS GENERAL HOSP HOUSTON TX 77087	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
RANGER GENERAL HOSPITAL RANGER TX 76470	1	0	0-97	1	0	1-97	2	0	0-95	.	.		15	7	1-35	9	22	1-50	1	0	0-100	24	4	1-25	7	0	0-93
REAGAN MEM HOSP BIG LAKE TX 76932	1	0	0-99	.	.		.	.		.	.		.	.		.	.		.	.		2	0	0-98	2	0	0-99
RED RIVER GEN HOSP CLARKSVILLE TX 75426	7	57	6-68	2	50	2-90	3	0	0-88	.	.		47	4	2-19	22	9	2-31	.	.		55	0	1-15	9	0	0-80
REEVES COUNTY HOSP PECOS TX 79772	3	33	2-82	7	29	8-70	4	0	1-74	.	.		20	5	0-29	2	0	0-93	2	0	0-100	14	7	0-38	3	0	0-100
RICHARDS MEMORIAL HOSPITAL ROCKDALE TX 76567	5	60	6-77	7	29	11-74	10	0	2-48	4	0	0-100	20	5	1-29	12	8	1-42	1	0	0-100	20	0	1-29	25	0	0-33
RICHARDSON MEDICAL CENTER RICHARDSON TX 75080	4	50	3-77	6	33	8-74	26	0	1-26	.	.		54	15	2-16	41	12	2-20	3	0	0-100	41	7	1-17	29	3	0-27
RIVERSIDE GEN HOSP HOUSTON TX 77004	.	.		.	.		.	.		.	.		3	33	1-81	1	0	0-100	.	.		2	0	0-95	1	0	0-100
ROBERT H DEDMAN MEM MED CT DALLAS TX 75381	8	38	8-67	7	14	9-72	33	15	2-25	4	25	0-100	69	9	2-14	23	0	1-28	6	0	0-100	71	7	2-13	56	2	0-13
ROLLING PLAINS MEMORIAL HO SWEETWATER TX 79556	8	13	4-62	8	13	12-72	5	20	0-76	1	0	0-100	58	2	2-16	30	3	3-28	1	0	0-100	56	2	2-15	13	0	0-49
ROLLINS BROOK HOSP LAMPASAS TX 76550	2	100	1-90	1	0	1-97	5	0	0-77	.	.		31	0	1-22	10	0	0-63	4	0	0-100	27	0	1-24	12	0	0-66
ROSEBUD COMMUNITY HOSPITAL ROSEBUD TX 76570	4	0	1-76	1	100	1-97	1	0	0-99	.	.		11	0	0-48	22	9	2-31	1	0	0-100	26	4	1-24	7	0	0-78
ROSEWOOD MEDICAL CENTER HOUSTON TX 77063	10	20	12-69	24	46	19-59	66	8	3-17	3	0	0-100	52	8	1-16	13	23	0-41	8	0	0-100	32	13	1-20	74	3	1-11
ROUND ROCK COMMUNITY HOSPI ROUND ROCK TX 78681	3	0	1-82	5	80	10-81	10	0	1-47	1	0	0-100	26	4	1-24	31	0	0-24	4	0	0-100	34	6	1-19	19	0	0-36
ROY H LAIRD MEM HOSP KILGORE TX 75662	6	67	7-74	7	29	14-77	13	0	0-41	.	.		54	4	1-15	18	28	2-34	5	0	0-100	52	10	2-16	15	0	0-61
SABINE COUNTY HOSPITAL HEMPHILL TX 75948	5	0	5-75	.	.		1	0	0-100	.	.		24	17	1-25	14	14	0-49	.	.		11	9	0-46	.	.	
SAINT JOSEPH HOSP FORT WORTH TX 76104	25	32	14-54	38	37	16-48	79	13	4-18	112	1	0-9	261	8	3-10	103	4	2-13	14	7	0-58	134	11	2-11	191	1	0-5
SAM HOUSTON MEM HOSP HOUSTON TX 77055	6	33	4-69	8	38	14-74	7	0	0-67	3	0	0-100	54	9	2-18	45	16	2-20	14	0	0-95	34	3	1-19	29	7	0-22
SAN ANTONIO STATE CHEST HO SAN ANTONIO TEXAS 78223	.	.		2	50	3-91	2	0	0-96	.	.		10	0	0-55	2	0	0-98	.	.		2	0	0-95	2	0	0-100

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
SAN AUGUSTINE MEMORIAL HOS SAN AUGUSTINE TX 75972	TX-403*	177	19	10-23	3	100	5-86	6	33	5-68	6	17	2-64	13	31	9-55	10	30	15-69	14	21	7-51	26	19	11-44
SAN JACINTO METHODIST HOSP BAYTOWN TX 77520	TX-404	627	14	10-18	29	21	13-46	22	41	13-51	16	31	6-46	45	16	13-38	18	61	24-68	17	41	11-53	84	18	13-32
SAN SABA HOSPITAL SAN SABA TX 76877	TX-405*	124	20	11-25	1	100	1-98	6	17	6-69	3	33	0-82	3	33	1-81	8	63	14-74	2	0	0-90	37	30	14-42
SANTA ROSA MEDICAL CENTER SAN ANTONIO TX 78207	TX-406	3537	11	8-15	177	24	19-37	114	21	19-37	66	26	9-30	198	23	18-31	72	40	26-50	83	27	13-35	278	22	16-29
SCENIC MOUNTAIN MEDICAL CE BIG SPRING TX 79720	TX-407	651	11	8-16	32	22	12-44	13	23	11-57	12	17	4-49	25	40	12-46	23	52	21-60	32	9	6-35	63	13	11-32
SCHLEICHER COUNTY MEDICAL ELDORADO TX 76936	TX-408	85	14	8-24	4	100	10-85	7	14	6-66	1	0	0-98	5	20	3-70	1	100	1-97	2	50	0-92	23	17	8-42
SCOTT WHITE MEM HOSP TEMPLE TX 76508	TX-409	3528	9	8-14	430	14	17-31	81	30	21-42	67	12	11-32	105	21	15-32	96	25	28-49	47	15	12-39	230	19	14-27
SETON MEDICAL CENTER AUSTIN TX 78705	TX-410	4329	10	8-14	390	23	18-32	125	25	20-38	83	28	13-34	182	20	16-29	126	29	29-48	46	15	10-36	367	18	14-25
SEYMOUR HOSP AUTHORITY SEYMOUR TX 76380	TX-411*	315	13	9-19	23	43	18-57	13	38	11-58	1	0	0-97	15	0	5-45	12	50	18-69	9	22	5-58	47	11	12-37
SHACKELFORD CO HOSP DISTRI ALBANY TX 76430	TX-412*	60	15	4-21	2	100	1-89	.	.		1	100	0-98	4	25	3-75	1	0	1-97	1	100	0-99	13	15	4-46
SHAMROCK GENERAL HOSP SHAMROCK TX 79079	TX-413	234	13	9-20	4	25	1-74	5	80	4-72	3	0	1-81	12	17	9-57	9	44	12-69	40	13	7-34	33	9	9-38
SHANNON WEST TEXAS MEM HOS SAN ANGELO TX 76902	TX-414	1753	13	8-15	146	13	14-32	48	40	16-41	25	36	8-41	66	18	14-34	69	29	27-51	32	28	7-36	186	27	13-27
SHARPSTOWN GENERAL HOSPITA HOUSTON TX 77074	TX-415*	715	10	8-16	45	22	13-41	26	19	15-49	27	26	7-38	29	10	10-41	18	44	20-63	24	13	6-39	43	28	12-38
SHELBY GENERAL HOSPITAL CENTER TX 75935	TX-416*	135	24	10-23	7	43	11-73	8	63	10-68	.	.		16	50	9-50	6	100	13-79	3	0	1-82	20	10	6-41
SHEPPERD MEMORIAL HOSP BURNET TX 78611	TX-417	439	18	9-18	14	79	10-56	18	44	12-52	11	27	5-53	36	36	11-38	31	45	22-56	8	0	2-56	45	20	8-32
SHILOH PARK HOSPITAL GARLAND TX 75041	TX-418*	3	0	0-87	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
SHINER HOSPITAL INC SHINER TX 77984	TX-419	256	16	11-22	15	0	5-45	12	17	10-59	7	29	9-70	13	15	7-52	12	42	19-71	20	40	7-45	42	17	10-35
SID PETERSON MEMORIAL HOSP KERRVILLE TX 78028	TX-420*	1520	10	9-15	103	16	14-34	42	33	17-45	34	18	6-34	77	23	16-36	45	40	29-58	33	21	7-37	147	16	14-29
SIERRA MEDICAL CENTER EL PASO TX 79902	TX-421	1673	8	7-14	91	16	16-37	37	14	15-44	29	10	7-37	70	30	14-35	59	27	28-54	22	23	6-41	113	21	12-29
SILSBEE DOCTORS HOSP SILSBEE TX 77656	TX-422*	486	16	10-18	8	63	8-65	22	50	13-50	9	11	1-52	43	28	11-36	11	36	17-69	28	29	5-36	87	24	10-28
SMITHVILLE HOSPITAL AUTHOR SMITHVILLE TX 78957	TX-423*	145	19	11-25	.	.		14	29	12-58	.	.		21	38	10-46	3	33	9-90	9	33	2-54	33	12	12-42
SOUTH LIMESTONE HOSP GROESBECK TX 76642	TX-424*	191	20	11-23	7	86	9-71	3	67	4-84	4	25	1-74	20	25	12-50	9	78	16-73	8	25	4-59	42	19	9-34
SOUTH PARK HOSP LUBBOCK TX 79413	TX-425*	545	8	6-14	27	22	13-48	14	14	10-54	7	0	1-58	20	5	9-45	9	56	16-73	17	12	3-40	52	6	9-32
SOUTH PLAINS HOSPITAL CLIN AMHERST TX 79312	TX-426*	114	17	7-21	2	100	2-90	2	0	1-89	3	33	1-81	11	18	6-54	5	20	7-77	7	0	1-59	15	20	7-49
SOUTHEASTERN METHODIST HOS DALLAS TX 75217	TX-427	564	16	10-18	23	22	7-41	23	26	11-47	12	17	2-46	60	22	14-36	36	31	22-54	20	25	6-42	49	27	8-31
SOUTHSIDE COMMUNITY HOSPIT CORPUS CHRISTI TX 78411	TX-428*	505	7	5-13	24	33	15-52	7	29	5-65	6	0	2-63	25	28	10-43	6	33	12-78	9	11	1-53	29	14	8-38

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Oisease			Sepsis			Severe Trauma			Ophthalmology			GI Oisease			Urology			Gynecology			Low Risk Heart Oisease			Orthopedics		
Name/ Location	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
SAN AUGUSTINE MEMORIAL HOS SAN AUGUSTINE TX 75972	3	33	3-84	1	100	1-97	1	0	0-100	.	.		14	0	0-38	13	15	2-41	.	.		23	17	1-26	4	0	0-99
SAN JACINTO METHODIST HOSP BAYTOWN TX 77520	6	17	4-69	15	40	18-65	24	8	2-29	4	0	0-100	84	5	3-15	36	6	1-21	8	0	0-88	39	3	1-18	25	0	0-35
SAN SABA HOSPITAL SAN SABA TX 76877	5	0	2-71	1	100	1-97	2	0	0-94	.	.		10	10	1-47	8	0	2-54	.	.		2	0	0-98	4	0	0-100
SANTA ROSA MEDICAL CENTER SAN ANTONIO TX 78207	42	26	11-44	43	35	23-54	57	9	3-19	28	0	0-54	293	2	3-10	224	8	3-12	30	0	0-32	268	3	3-8	142	1	0-6
SCENIC MOUNTAIN MEDCIAL CE BIG SPRING TX 79720	15	27	9-57	13	31	15-65	19	0	1-32	.	.		62	3	1-14	63	5	2-16	16	0	0-87	47	4	1-16	34	3	0-23
SCHLEICHER COUNTY MEDICAL ELDORADO TX 76936	.	.		.	.		.	.		.	.		2	0	0-100	7	0	0-60	.	.		9	0	0-57	1	0	0-100
SCOTT WHITE MEM HOSP TEMPLE TX 76508	21	0	4-44	13	46	16-67	82	4	3-17	39	0	0-51	323	6	3-9	277	4	1-10	29	0	0-92	318	8	3-8	300	0	0-4
SETON MEDICAL CENTER AUSTIN TX 78705	26	27	11-51	27	63	26-64	155	5	4-15	79	0	0-14	477	5	3-8	208	7	2-10	50	2	0-53	442	3	3-7	334	1	0-4
SEYMOUR HOSP AUTHORITY SEYMOUR TX 76380	10	20	6-61	.	.		2	0	0-95	.	.		35	3	1-19	20	5	0-32	3	0	0-100	30	3	0-21	17	0	0-33
SHACKELFORO CO HOSP OISTRI ALBANY TX 76430	1	0	0-99	.	.		.	.		.	.		7	0	0-58	2	0	0-99	.	.		1	100	0-100	2	0	0-100
SHAMROCK GENERAL HOSP SHAMROCK TX 79079	9	33	8-65	6	83	7-72	1	0	0-100	.	.		21	0	0-28	1	0	0-100	2	0	0-100	21	0	1-27	6	0	0-95
SHANNON WEST TEXAS MEM HOS SAN ANGELO TX 76902	25	20	8-46	16	56	16-62	74	8	2-16	6	0	0-100	185	8	3-11	112	6	1-12	15	0	0-99	130	8	2-10	140	1	0-6
SHARPSTOWN GENERAL HOSPITA HOUSTON TX 77074	9	33	6-63	20	20	15-56	34	3	3-25	2	0	0-100	91	0	2-13	46	2	1-19	11	0	0-100	44	9	1-17	52	2	0-13
SHELBY GENERAL HOSPITAL CENTER TX 75935	2	100	1-90	1	100	1-97	1	0	0-97	.	.		16	0	0-34	5	0	1-67	1	0	0-100	5	0	0-75	7	0	0-79
SHEPPERO MEMORIAL HOSP BURNET TX 78611	6	67	7-73	5	40	8-78	12	0	0-43	.	.		56	5	1-15	22	9	1-29	.	.		43	7	1-17	16	0	0-47
SHILOH PARK HOSPITAL GARLAND TX 75041	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
SHINER HOSPITAL INC SHINER TX 77984	7	43	5-66	7	43	13-76	5	0	1-67	.	.		20	10	0-29	16	19	2-36	2	0	0-100	9	0	0-50	2	0	0-100
SID PETERSON MEMORIAL HOSP KERRVILLE TX 78028	5	20	8-80	23	30	20-60	80	3	3-17	6	0	0-100	186	4	2-10	90	2	1-13	12	0	0-100	92	5	2-11	138	3	0-6
SIERRA MEDICAL CENTER EL PASO TX 79902	24	17	9-49	11	36	17-71	45	4	4-23	62	0	0-20	180	3	2-10	73	4	1-14	15	0	0-83	205	4	2-8	169	0	0-6
SILSBEE DOCTORS HOSP SILSBEE TX 77656	32	6	13-50	2	100	8-97	3	33	0-88	.	.		39	3	1-18	19	5	1-31	.	.		41	2	1-17	22	0	0-35
SMITHVILLE HOSPITAL AUTHOR SMITHVILLE TX 78957	4	50	6-82	.			2	0	0-92	.	.		11	9	0-49	2	0	0-100	.	.		10	0	0-50	2	0	0-97
SOUTH LIMESTONE HOSP GROESBECK TX 76642	3	0	6-88	1	100	2-99	.	.			.		10	10	1-47	10	10	1-47	1	0	0-100	19	5	1-30	6	0	0-98
SOUTH PARK HOSP LUBBOCK TX 79413	9	22	7-65	2	0	4-93	7	0	0-59	3	0	0-100	63	2	1-13	26	8	0-26	4	0	0-100	82	6	2-14	43	0	0-23
SOUTH PLAINS HOSPITAL CLIN AMHERST TX 79312	4	50	2-76	.	.		2	100	0-90	.	.		9	0	0-55	4	25	0-76	.	.		6	17	0-65	1	0	0-100
SOUTHEASTERN METHODIST HOS DALLAS TX 75217	4	75	4-79	12	8	17-69	21	10	2-31		.		54	9	2-17	17	18	1-34	2	0	0-100	58	10	1-15	17	0	0-46
SOUTHSIDE COMMUNITY HOSPIT CORPUS CHRISTI TX 78411	2	50	2-90	1	0	0-97	6	0	1-63	56	2	0-19	44	0	1-18	20	10	0-30	2	0	0-100	26	4	1-23	36	0	0-24

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
SOUTHWEST GENERAL HOSP SAN ANTONIO TX 78224	TX-429	1417	13	9-16	60	27	13-37	35	37	17-47	30	23	10-42	72	28	16-36	50	56	25-52	87	20	10-31	137	18	13-29
SOUTHWEST TEXAS METHODIST SAN ANTONIO TX 78229	TX-430	3532	9	8-14	317	19	17-31	146	23	20-36	52	23	8-32	145	21	16-31	105	29	27-47	63	13	8-31	219	16	13-26
SOUTHWESTERN GEN HOSP EL PASO TX 79902	TX-431*	260	10	7-17	8	0	5-61	6	50	6-70	9	11	4-55	12	33	9-57	6	33	10-75	15	13	2-42	37	11	10-37
SPOHN HOSP CORPUS CHRISTI TX 78404	TX-432	4023	10	8-14	326	21	16-31	107	26	18-36	93	17	10-29	198	22	18-31	125	35	28-46	57	5	8-32	253	19	14-26
SPOHN KLEBERG MEMORIAL HOS KINGSVILLE TX 78363	TX-433	495	13	9-17	32	47	14-46	27	41	13-46	10	10	2-49	42	12	12-38	17	29	17-61	7	0	1-59	55	13	9-32
SPRING BRANCH MEM HOSP HOUSTON TX 77055	TX-434	1043	9	7-14	61	28	15-39	25	36	14-49	28	18	7-38	63	16	12-33	29	17	20-54	15	20	7-50	60	12	10-31
ST ANTHONYS HOSP AMARILLO TX 79107	TX-435*	2843	12	8-15	337	26	19-34	52	42	20-46	42	40	12-40	69	25	15-36	94	27	26-47	36	22	7-35	185	18	13-27
ST DAVIDS COMM HOSP AUSTIN TX 78705	TX-436	2567	10	8-14	222	23	16-32	110	25	19-37	41	12	7-32	92	22	16-34	83	40	26-48	42	7	10-38	151	23	13-28
ST EDWARD HOSPITAL CAMERON TX 76520	TX-437	172	20	10-23	11	36	9-59	7	43	9-70	3	67	1-81	15	33	10-53	13	54	16-65	8	25	5-61	27	11	9-41
ST ELIZABETH HOSP BEAUMONT TX 77702	TX-438	3464	11	9-15	209	24	19-36	127	20	18-35	76	11	8-28	194	28	17-30	123	30	27-46	82	32	13-35	234	20	14-27
ST ELIZABETH HOSP OF HOUST HOUSTON TX 77020	TX-439	208	15	7-18	8	50	9-67	9	33	9-63	6	33	1-63	22	23	8-42	4	25	6-80	11	18	5-54	13	15	3-44
ST JOHN HOSPITAL NASSAU BAY TX 77058	TX-440	291	8	7-16	22	23	12-50	8	13	6-62	10	10	4-54	12	17	7-54	8	38	17-77	8	13	1-56	20	15	6-40
ST JOHNS HOSPITAL AND HLTH SAN ANGELO TX 76905	TX-441	1073	9	8-15	72	24	15-37	20	15	16-56	27	33	9-42	49	22	14-39	31	39	20-54	21	14	6-41	95	11	10-27
ST JOSEPH HOSPITAL & HEALT BRYAN TX 77802	TX-442	1018	14	9-16	92	18	14-34	44	25	15-42	16	31	4-43	50	30	14-39	47	45	26-55	32	19	8-39	82	18	12-31
ST JOSEPHS HOSP HOUSTON TX 77002	TX-443	3343	13	9-15	275	23	17-32	134	29	19-35	69	19	8-28	229	17	16-28	92	34	28-49	130	33	12-31	187	18	14-29
ST JOSEPHS HOSP & HEALTH C PARIS TX 75460	TX-444	1473	13	9-16	121	23	16-35	48	27	17-43	11	0	4-51	86	23	16-34	51	53	27-54	23	4	6-40	112	21	13-30
ST JUDE HOSPITAL BRENHAM TX 77833	TX-445	405	21	9-18	38	24	9-37	20	65	14-53	16	38	7-48	22	23	9-44	15	47	17-63	17	24	7-47	41	49	11-38
ST LUKES EPISCOPAL HOSP HOUSTON TX 77030	TX-446	4068	10	6-12	225	17	14-30	104	20	20-39	46	17	10-36	201	19	15-28	183	32	27-44	47	23	10-36	131	17	11-27
ST LUKES LUTHERAN HOSP SAN ANTONIO TX 78229	TX-447	1534	11	8-15	142	25	18-36	40	28	16-45	18	22	6-43	65	22	14-35	28	25	24-60	39	21	11-40	131	24	13-29
ST MARY HOSPITAL OF PT ART PORT ARTHUR TX 77642	TX-448	1709	13	9-15	106	26	16-36	61	34	18-41	34	12	7-35	107	31	15-31	66	36	24-49	41	32	9-36	96	24	12-30
ST MARY OF THE PLAINS HOSP LUBBOCK TX 79410	TX-449	2054	8	7-14	98	20	20-41	37	24	15-44	28	14	6-35	84	19	15-34	66	29	25-49	21	19	8-44	159	19	15-30
ST MARYS HOSP GALVESTON TX 77550	TX-450	1244	10	8-15	66	18	12-35	52	13	16-40	40	10	6-30	56	25	14-37	50	46	27-55	37	30	8-37	59	29	12-34
ST PAUL MEDICAL CTR DALLAS TX 75235	TX-451	2369	12	9-15	192	22	16-32	117	23	19-37	42	21	9-35	109	20	15-31	88	31	27-49	67	25	9-32	148	21	13-28
STAMFORD MEMORIAL HOSP STAMFORD TX 79553	TX-452*	365	10	8-17	16	25	8-50	12	25	9-57	14	21	4-45	20	20	10-46	11	36	17-70	9	33	2-53	52	17	10-33
STARLITE VILLAGE HOSPITAL CENTER POINT TX 78010	TX-453*	50	2	2-19	.	.		1	0	0-97	.	.		.	.		.	.		.	.		2	50	0-90
STARR CO MEMORIAL HOSP RIO GRANDE CITY TX 78582	TX-454*	298	14	9-19	11	36	11-63	13	54	10-57	7	14	5-64	17	18	9-49	10	50	14-68	10	40	6-58	33	18	12-42

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
SOUTHWEST GENERAL HOSP SAN ANTONIO TX 78224	22	9	6-46	16	44	18-64	26	8	2-28	3	0	0-100	184	6	3-10	92	3	2-15	17	0	0-78	108	3	2-11	62	2	0-11
SOUTHWEST TEXAS METHODIST SAN ANTONIO TX 78229	31	10	8-45	28	57	22-60	106	8	4-16	69	0	0-16	319	1	3-8	196	3	1-10	62	0	0-24	377	5	2-7	310	1	0-4
SOUTHWESTERN GEN HOSP EL PASO TX 79902	4	25	2-76	1	0	1-97	7	14	3-60	.	.		34	3	1-21	12	0	0-43	2	0	0-100	13	0	0-39	14	0	0-61
SPOHN HOSP CORPUS CHRISTI TX 78404	45	16	8-41	27	41	21-59	91	9	5-19	34	0	0-50	455	5	3-9	200	3	1-10	43	0	0-38	482	6	3-7	230	1	0-5
SPOHN KLEBERG MEMORIAL HOS KINGSVILLE TX 78363	3	0	1-83	10	30	11-66	8	25	0-55	.	.		64	5	1-13	26	4	1-26	2	0	0-100	38	0	1-17	6	0	0-99
SPRING BRANCH MEM HOSP HOUSTON TX 77055	8	25	6-65	11	64	16-70	32	13	2-24	2	0	0-100	101	2	2-11	50	4	1-17	7	0	0-100	166	4	2-9	72	0	0-12
ST ANTHONYS HOSP AMARILLO TX 79107	34	38	13-50	14	21	17-66	111	7	3-15	.	.		296	6	3-9	241	2	1-10	20	0	0-96	259	7	3-9	319	2	0-4
ST DAVIDS COMM HOSP AUSTIN TX 78705	18	28	7-51	16	38	21-67	71	8	2-17	17	0	0-96	264	4	2-9	155	2	1-11	40	0	0-63	246	5	3-8	224	3	0-5
ST EDWARD HOSPITAL CAMERON TX 76520	2	0	1-90	1	100	2-98	4	0	0-78				12	8	0-48	16	25	0-35	.			6	0	0-76	6	0	0-93
ST ELIZABETH HOSP BEAUMONT TX 77702	39	33	16-51	27	26	18-56	93	9	3-16	19	5	0-58	319	7	3-9	175	3	1-11	31	3	0-25	541	5	3-7	184	2	0-6
ST ELIZABETH HOSP OF HOUST HOUSTON TX 77020	1	0	3-99	3	67	7-89	5	0	0-69	.	.		27	0	1-23	10	10	1-47	1	0	0-100	18	0	0-31	5	0	0-100
ST JOHN HOSPITAL NASSAU BAY TX 77058	.	.		1	100	2-98	7	0	1-58	8	0	0-100	39	3	1-18	24	0	0-29	7	0	0-99	18	6	0-32	10	0	0-71
ST JOHNS HOSPITAL AND HLTH SAN ANGELO TX 76905	10	20	5-59	13	31	17-67	21	14	2-32	34	0	0-46	103	3	2-11	51	6	1-17	1	0	0-100	81	6	2-13	89	0	0-9
ST JOSEPH HOSPITAL & HEALT BRYAN TX 77802	11	18	13-68	15	40	15-62	48	15	3-21	3	0	0-100	113	7	2-11	48	2	1-17	17	0	0-47	78	5	2-13	74	1	0-10
ST JOSEPHS HOSP HOUSTON TX 77002	28	21	8-45	39	38	22-55	67	9	3-18	14	0	0-85	344	8	3-8	163	10	2-12	32	0	0-45	234	8	3-9	124	1	0-7
ST JOSEPHS HOSP & HEALTH C PARIS TX 75460	13	31	7-57	13	62	19-69	49	6	3-22	1	0	0-100	138	10	3-12	134	5	3-13	24	0	0-65	118	3	2-10	74	3	0-10
ST JUDE HOSPITAL BRENHAM TX 77833	5	60	10-81	1	100	1-97	10	0	1-47				65	6	1-14	22	0	1-29	5	0	0-100	18	17	0-31	20	5	0-44
ST LUKES EPISCOPAL HOSP HOUSTON TX 77030	22	23	5-44	9	44	15-73	56	11	3-21	16	0	0-98	266	3	2-8	146	1	1-11	35	0	0-47	1243	9	3-6	242	1	0-5
ST LUKES LUTHERAN HOSP SAN ANTONIO TX 78229	15	13	9-56	19	0	12-53	58	16	4-21	18	0	0-87	155	3	2-10	75	8	1-15	14	0	0-88	114	5	2-11	154	1	0-6
ST MARY HOSPITAL OF PT ART PORT ARTHUR TX 77642	19	5	6-49	17	41	15-59	53	8	4-22	4	0	0-100	193	3	3-10	87	7	2-14	10	0	0-100	232	4	3-9	93	2	0-8
ST MARY OF THE PLAINS HOSP LUBBOCK TX 79410	12	25	6-56	17	59	18-63	31	3	3-27	5	0	0-100	168	5	2-10	63	2	1-15	31	0	0-42	409	4	3-7	187	3	0-5
ST MARYS HOSP GALVESTON TX 77550	17	35	14-61	10	0	12-67	32	9	2-25	4	0	0-100	123	4	2-10	62	2	1-16	16	0	0-99	99	4	2-11	79	0	0-9
ST PAUL MEDICAL CTR DALLAS TX 75235	25	28	9-48	19	37	16-59	73	5	3-18	37	0	0-51	189	4	3-10	78	4	1-14	17	6	0-82	279	7	3-8	140	1	0-6
STAMFORD MEMORIAL HOSP STAMFORD TX 79553	14	7	6-53	1	0	1-97	5	0	0-72	.	.		41	0	1-17	6	0	1-62	1	0	0-100	48	4	1-15	9	0	0-91
STARLITE VILLAGE HOSPITAL CENTER POINT TX 78010	1	0	0-97	.	.		.	.		.	.		1	0	0-100	.	.		.	.		.	.		.	.	
STARR CO MEMORIAL HOSP RIO GRANDE CITY TX 78582	8	38	7-67	2	50	2-91	1	0	0-100	.	.		51	8	1-16	9	11	3-53	5	0	0-100	20	0	1-28	4	0	0-100

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
STEPHENS MEM HOSP BRECKENRIDGE TX 76024	TX-455	196	28	11-22	7	86	9-70	12	58	9-57	2	50	0-91	12	33	6-52	18	44	16-58	11	27	4-52	38	21	9-35						
STERLING COUNTY HOSPITAL STERLING CITY TX 76951	TX-456*	9	22	2-51	.	.		.	.		.	.		1	100	1-97	.	.		1	0	0-99	.	.							
STONEWALL MEM HOSP ASPERMONT TX 79502	TX-457	73	11	7-24	.	.		1	100	1-97	3	0	1-81	2	0	2-90	6	67	16-83	3	33	1-81	17	6	6-43						
SUN BELT REGIONAL MEDICAL HOUSTON TX 77015	TX-458*	548	14	8-16	31	42	10-41	23	26	12-48	9	33	4-56	27	22	8-38	21	29	18-58	8	0	2-56	69	26	12-32						
SUN BELT REGIONAL MEDICAL CHANNELVIEW TEXAS 77530	TX-459*	234	15	7-17	17	59	12-55	8	38	7-63	1	0	0-97	14	29	7-50	9	44	8-63	3	0	0-82	39	10	5-28 8						
SWEENY COMMUNITY HOSP SWEENY TX 77480	TX-460	208	9	10-22	7	29	9-70	13	31	10-57	6	0	2-63	9	22	5-57	7	29	10-71	8	13	7-65	41	12	10-36						
SWISHER MEMORIAL HOSPITAL TULIA TX 79088	TX-461*	116	20	8-22	.	.		11	45	7-56	3	33	2-82	16	44	10-51	3	33	8-89	1	0	0-99	16	25	6-45						
TAFT HOSP DISTRICT TAFT TX 78390	TX-462*	266	14	8-18	9	33	4-56	16	19	12-55	4	25	1-74	15	40	9-51	8	25	16-76	15	7	3-43	31	35	10-40						
TEAGUE GENERAL HOSP TEAGUE TX 75860	TX-463*	203	15	8-19	4	25	4-77	9	22	9-64	1	0	0-98	10	10	6-56	10	40	13-67	2	50	1-89	33	24	9-38 8						
TERRELL COMMUNITY HOSPITAL TERRELL TX 75160	TX-464	404	16	8-17	11	18	6-55	12	25	10-58	10	30	2-50	18	6	8-46	21	57	20-60	22	36	5-39	48	25	11-35						
TEXARKANA COMMUNITY HOSPIT TEXARKANA TX 75505	TX-465	604	11	9-17	36	39	15-46	21	33	15-53	18	22	6-44	22	27	14-51	14	21	19-67	17	0	5-44	78	8	10-29						
TEXOMA MEDICAL CENTER DENISON TX 75020	TX-466	2042	12	10-16	132	23	18-36	81	33	22-44	34	21	7-35	110	18	15-32	93	38	27-48	59	27	12-37	184	17	13-27						
THE HEART OF TEXAS MEMORIA BRADY TX 76825	TX-467*	300	15	11-21	14	21	8-53	24	46	17-54	10	10	5-55	13	31	11-57	15	27	17-63	8	13	4-60	49	14	10-34						
THE INST FOR IMMUNOLOGICAL HOUSTON TX 77076	TX-468	85	26	6-21	4	75	4-77	5	40	5-73	1	100	0-98	3	0	1-81	5	40	5-74	8	25	2-56	11	45	3-49						
THE METHODIST HOSPITAL HOUSTON TX 77030	TX-469	6551	7	5-12	435	17	17-31	133	23	18-35	92	16	9-28	164	16	16-30	160	28	28-45	69	20	8-30	203	22	13-27						
THE RANKIN CO HOSP DIST RANKIN TX 79778	TX-470*	19	21	3-36	.	.		1	0	0-97	1	100	0-97	.	.		2	100	5-93	1	0	0-98	4	0	0-76						
THE UNIVERSITY OF TEXAS HE TYLER TX 75710	TX-471	1154	17	11-18	114	44	24-45	9	33	9-64	12	17	5-50	85	19	13-31	23	39	20-58	16	50	12-56	267	18	12-24						
THE WOODLANDS COMMUNITY HO THE WOODLANDS TEXAS 77380	TX-472	196	15	7-18	8	50	4-59	2	0	1-89	4	0	1-75	16	25	8-48	12	58	17-69	4	25	4-78	21	14	8-44						
THROCKMORTON CO MEMORIAL H THROCKMORTON TX 76083	TX-473*	66	12	4-20	2	50	2-90	2	50	2-90	1	0	0-100	1	100	1-97	2	50	5-93	.	.		8	13	2-55						
TIGUA GENERAL HOSP EL PASO TX 79915	TX-474*	236	9	6-16	11	27	9-60	5	40	7-76	4	50	3-76	21	19	8-42	3	100	5-86	7	14	2-59	20	5	5-39						
TITUS CO MEMORIAL HOSP MOUNT PLEASANT TX 75455	TX-475*	1022	16	9-16	64	36	11-34	30	37	14-45	23	9	6-39	62	27	13-35	35	46	23-56	23	26	6-41	141	33	15-31						
TOMBALL REGIONAL HOSPITAL TOMBALL TX 77375	TX-476	904	10	8-16	39	18	14-43	30	20	18-51	25	28	6-38	51	18	13-36	24	42	23-61	27	26	9-42	95	14	11-29						
TORBETT HUTCHINGS SMITH ME MARLIN TX 76661	TX-477*	289	21	11-21	13	31	4-47	31	23	17-50	5	20	3-70	18	50	9-47	22	64	22-62	7	43	1-59	34	29	11-41						
TRI CITY COMM HOSP JOURDANTON TX 78026	TX-478	380	16	9-18	1	100	0-98	8	25	9-67	9	33	4-56	21	29	12-49	9	44	14-71	18	17	7-46	37	24	9-36						
TRINITY MEDICAL CENTER CARROLLTON TX 75010	TX-479	189	13	8-20	8	25	12-72	9	22	10-66	6	17	3-66	8	25	4-59	5	40	6-75	5	0	1-68	20	30	7-42						
TRINITY MEMORIAL HOSPITAL TRINITY TX 75862	TX-480*	162	20	9-22	11	36	6-55	6	50	5-69	1	0	0-100	6	33	6-70	9	22	14-71	4	25	1-74	25	16	9-41						

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																				
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
STEPHENS MEM HOSP BRECKENRIDGE TX 76024	2	50	1-90	.	.		4	0	0-82	.	.		10	10	1-46	5	0	0-72	.	.		18	28	1-31	5	0	0-96
STERLING COUNTY HOSPITAL STERLING CITY TX 76951	1	0	0-97	.	.					.	.		.	.		.	.		.	.		2	0	0-95	1	0	0-100
STONEWALL MEM HOSP ASPERMONT TX 79502	.	.		1	0	0-97	1	0	0-100	1	0	0-100	5	0	0-77	1	0	0-100	.	.		3	0	0-84	2	0	0-100
SUN BELT REGIONAL MEDICAL HOUSTON TX 77015	8	13	5-64	6	17	9-74	20	5	1-30	1	0	0-100	61	7	2-16	27	15	1-25	1	0	0-100	22	14	1-27	58	2	0-12 8
SUN BELT REGIONAL MEDICAL CHANNELVIEW TEXAS 77530	3	33	1-83	2	50	9-97	6	0	0-66	1	0	0-100	23	4	1-27	11	0	0-64	4	0	0-100	19	15	0-30	14	0	0-65
SWEENY COMMUNITY HOSP SWEENY TX 77480	4	0	3-78	3	0	13-73	2	0	0-90	.	.		25	0	1-24	18	6	1-32	2	0	0-100	13	0	1-39	3	0	0-99
SWISHER MEMORIAL HOSPITAL TULIA TX 79088	1	100	1-97	.	.		1	0	0-100	.	.		12	0	0-41	1	0	0-100	.	.		6	0	0-56	7	0	0-94
TAFT HOSP DISTRICT TAFT TX 78390	4	50	4-79	1	100	0-97	10	0	0-43	.	.		59	5	2-16	10	10	1-47	2	0	0-100	12	0	0-42	11	0	0-81
TEAGUE GENERAL HOSP TEAGUE TX 75860	1	100	0-97	2	50	1-99	3	33	0-83	.	.		22	9	1-27	13	8	1-41	.	.		13	0	0-41	8	0	0-63 8
TERRELL COMMUNITY HOSPITAL TERRELL TX 75160	2	0	0-90	10	30	16-74	12	8	1-42	.	.		41	5	1-19	20	15	1-30	4	0	0-100	44	7	1-17	29	3	0-25
TEXARKANA COMMUNITY HOSPIT TEXARKANA TX 75505	7	29	2-63	13	46	19-70	20	10	4-36	1	0	0-100	72	4	2-14	29	7	1-24	1	0	0-100	60	7	2-15	44	0	0-16
TEXOMA MEDICAL CENTER DENISON TX 75020	21	38	8-50	14	21	19-68	49	12	6-26	3	0	0-100	174	3	2-10	94	6	1-19	15	0	0-92	204	3	3-9	153	2	0-6
THE HEART OF TEXAS MEMORIA BRADY TX 76825	7	29	9-73	2	0	3-91	4	50	1-74	1	0	0-100	56	8	1-20	18	11	2-32	2	0	0-100	27	11	1-23	5	0	0-87
THE INST FOR IMMUNOLOGICAL HOUSTON TX 77076	.	.		1	100	2-93	2	50	0-99	.	.		9	33	0-60	6	17	0-71	.	.		5	0	0-81	3	0	0-100
THE METHODIST HOSPITAL HOUSTON TX 77030	55	11	8-39	22	36	18-59	81	4	3-17	336	0	0-2	389	5	3-8	213	2	1-10	42	0	0-34	1068	5	3-8	511	1	0-3
THE RANKIN CO HOSP DIST RANKIN TX 79778	.	.		.	.					.	.		1	0	0-100	.	.		.	.		3	0	0-84	.	.	
THE UNIVERSITY OF TEXAS HE TYLER TX 75710	7	0	6-68	4	25	12-87	2	50	0-93	.	.		39	10	1-18	8	50	2-54	.	.		170	8	2-8	19	0	0-33
THE WOODLANDS COMMUNITY HO THE WOODLANDS TEXAS 77380	.	.		1	100	2-98	8	0	1-53	.	.		23	0	0-27	15	7	1-33	.	.		17	6	0-62	17	0	0-50
THROCKMORTON CO MEMORIAL H THROCKMORTON TX 76083	.	.		.	.		3	0	0-85	.	.		3	0	0-97	2	0	0-96	.	.		13	0	0-40	6	0	0-95
TIGUA GENERAL HOSP EL PASO TX 79915	4	25	5-81	.	.		7	14	1-57	.	.		29	0	0-22	8	0	0-77	3	0	0-100	25	0	1-24	10	0	0-93
TITUS CO MEMORIAL HOSP MOUNT PLEASANT TX 75455	7	29	5-67	9	33	13-70	32	9	2-24	.	.		115	3	2-11	62	2	1-15	7	0	0-100	90	3	2-11	46	0	0-16
TOMBALL REGIONAL HOSPITAL TOMBALL TX 77375	13	15	9-60	9	44	9-86	17	0	1-34	3	0	0-100	108	2	2-12	52	2	2-18	6	0	0-89	100	5	2-11	53	0	0-13
TORBETT HUTCHINGS SMITH ME MARLIN TX 76661	3	33	5-86	2	50	5-94	4	0	0-80	.	.		40	5	1-18	30	0	1-23	2	0	0-100	17	12	1-52	7	0	0-65
TRI CITY COMM HOSP JOURDANTON TX 78026	7	29	4-66	21	48	22-64	8	13	0-55	.	.		40	8	1-18	25	8	1-27	2	0	0-100	27	0	1-23	4	0	0-100
TRINITY MEDICAL CENTER CARROLLTON TX 75010	5	20	3-72	2	50	5-97	9	0	2-51	.	.		27	11	1-23	10	10	1-47	1	0	0-100	17	0	1-52	8	0	0-64 3
TRINITY MEMORIAL HOSPITAL TRINITY TX 75862	6	33	9-77	1	100	2-98	2	50	0-95	.	.		20	5	0-29	6	17	0-64	2	0	0-100	22	5	1-27	1	0	0-100

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
TYLER CO HOSP WOODVILLE TX 75979	TX-481*	371	11	8-17	5	80	6-75	23	17	14-51	6	17	1-63	22	32	10-45	13	23	17-66	8	13	1-56	45	16	8-32
UNIVERSITY OF TEXAS-MEDICA GALVESTON TX 77550	TX-482*	1921	11	7-13	154	29	17-35	44	34	15-42	36	25	7-34	52	19	12-35	30	43	21-55	69	14	9-31	94	23	11-28
US AIR FORCE HOSP SAN ANTONIO TX 78236	TX-483	7	86	0-65	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
US ARMY HOSP FORT SAM HOUSTON TX 78234	TX-484*	7	71	0-73	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
UT SYSTEM CANCER CTR MD AN HOUSTON TX 77030	TX-485*	1528	13	18-25	790	17	23-36	5	60	8-77	21	19	15-54	7	14	8-69	1	100	1-97	20	30	21-63	36	28	17-47
UVALDE MEM HOSPITAL UVALDE TX 78801	TX-486*	470	16	10-19	13	23	7-52	23	26	13-49	25	24	7-39	38	16	12-39	27	41	26-62	17	41	6-46	65	22	11-32
VAL VERDE MEMORIAL HOSP DEL RIO TX 78840	TX-487*	644	13	9-17	30	40	15-49	29	34	14-46	11	18	5-52	50	22	12-36	20	45	23-65	28	11	7-39	65	20	12-33
VALLEY BAPTIST MEDICAL CEN HARLINGEN TX 78550	TX-488	2724	12	8-15	209	31	17-34	92	20	16-35	49	20	10-34	110	27	14-31	118	43	28-47	37	14	8-36	161	22	14-29
VICTORIA REGIONAL MEDICAL VICTORIA TEXAS 77901	TX-489*	502	8	8-16	45	18	14-42	34	12	14-44	4	25	3-75	14	21	10-55	9	33	14-71	8	38	5-62	20	30	11-50
VILLAGE OAKS REGIONAL HOSP SAN ANTONIO TX 78233	TX-490	358	11	8-17	19	16	12-53	16	25	11-53	7	43	2-59	21	24	8-43	12	33	14-64	5	40	5-74	33	12	7-34
WADLEY REGIONAL MEDICAL CE TEXARKANA TX 75501	TX-491*	2176	10	8-14	138	14	14-32	84	32	19-39	34	18	6-33	89	20	15-33	52	38	24-51	35	26	9-39	139	22	15-31
WAGNER GENERAL HOSP PALACIOS TX 77465	TX-492	134	13	9-23	1	0	2-98	7	14	7-68	3	0	0-82	8	50	7-64	5	20	8-77	4	50	5-80	22	27	12-48
WALLS REGIONAL HOSPITAL CLEBURNE TX 76031	TX-493	1107	12	8-15	58	26	12-36	37	32	16-46	34	9	5-32	63	16	12-33	50	44	25-52	19	26	5-42	130	18	11-27
WARD MEMORIAL HOSP MONAHANS TX 79756	TX-494*	213	11	9-21	5	80	13-84	7	43	9-70	4	0	0-79	17	12	10-50	5	60	18-88	13	15	4-49	34	6	10-38
WEST COKE CO HOSP DISTRICT ROBERT LEE TX 76945	TX-495*	26	23	5-34	2	100	4-92	.	.		.	.		1	100	1-97	1	100	1-97	1	0	0-97	7	0	2-59
WEST COMM HOSP WEST TX 76691	TX-496*	244	13	10-21	8	25	8-66	19	26	14-54	3	33	3-83	18	22	8-46	5	40	9-79	14	14	5-49	41	15	8-33
WEST HOUSTON MEDICAL CENTE HOUSTON TX 77082	TX-497	375	9	6-14	15	33	9-53	5	20	6-75	12	0	3-47	18	17	6-43	9	56	13-69	6	0	1-64	28	25	7-37
WEST PLAINS MEDICAL CENTER MULESHOE TX 79347	TX-498*	95	8	7-21	2	50	1-89	4	100	3-76	2	0	0-90	6	0	2-63	3	33	8-89	2	0	1-89	14	0	7-50
WEST TEXAS HOSP LUBBOCK TX 79401	TX-499*	275	14	6-16	13	54	10-58	7	57	9-70	9	33	3-55	7	57	7-68	3	67	6-87	2	50	0-91	30	17	8-37
WICHITA GEN HOSP WICHITA FALLS TX 76301	TX-500*	1812	14	8-15	144	24	16-34	55	31	17-41	27	15	4-33	91	23	14-32	48	52	25-53	66	38	12-36	119	27	13-29
WILBARGER GENERAL HOSP VERNON TX 76384	TX-501*	513	16	10-19	24	29	14-51	18	44	14-55	11	18	3-50	31	39	11-41	19	63	24-66	29	24	6-36	86	22	14-33
WILLACY METHODIST HOSP RAYMONDVILLE TX 78580	TX-502*	73	29	13-32	1	0	0-98	8	63	12-72	2	0	0-93	3	0	3-83	5	40	8-78	6	33	1-63	15	33	7-49
WILLIAM BEAUMONT GEN HOSP EL PASO TX 79920	TX-503*	12	92	0-43	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
WILSON MEMORIAL HOSP FLORESVILLE TX 78114	TX-504	257	16	10-21	10	50	12-67	13	15	11-58	4	25	1-74	11	45	9-59	18	28	19-62	4	0	2-75	32	22	12-43
WILSON N JONES MEMORIAL HO SHERMAN TX 75090	TX-505	1565	10	8-15	93	15	13-34	51	25	16-42	34	24	8-37	99	25	16-33	61	30	26-51	22	23	5-40	132	22	14-30
WINTER GARDEN HOSPITAL DILLEY TX 78017	TX-506	131	18	9-22	7	43	7-67	8	38	9-66	1	0	0-98	10	30	7-59	6	67	9-75	5	20	2-69	19	26	6-41

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
TYLER CO HOSP WOODVILLE TX 75979	10	0	4-57	6	17	9-75	.	.	.	1	0	0-100	58	5	2-15	12	8	1-42	1	0	0-100	42	5	1-17	9	0	0-99
UNIVERSITY OF TEXAS-MEDICA GALVESTON TX 77550	61	7	4-34	15	80	15-53	21	19	2-31	47	2	0-28	128	5	2-11	55	5	1-13	18	0	0-100	159	5	2-10	102	2	0-8
US AIR FORCE HOSP SAN ANTONIO TX 78236	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
US ARMY HOSP FORT SAM HOUSTON TX 78234	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.	.
UT SYSTEM CANCER CTR MD AN HOUSTON TX 77030	7	0	3-64	11	27	19-73	2	0	0-95				28	4	3-27	23	9	3-31	8	0	0-100	11	45	3-47	5	20	0-75
UVALDE MEM HOSPITAL UVALDE TX 78801	3	33	1-82	4	50	11-87	13	0	1-40	2	0	0-100	55	9	2-17	13	8	1-40	4	0	0-100	41	2	1-18	12	0	0-46
VAL VERDE MEMORIAL HOSP DEL RIO TX 78840	21	24	9-50	10	40	13-68	16	0	1-35	1	0	0-100	79	3	2-13	35	0	1-21	9	0	0-100	54	2	1-14	15	6	0-55
VALLEY BAPTIST MEDICAL CEN HARLINGEN TX 78550	14	36	6-54	40	30	21-53	64	9	4-21	30	0	0-52	280	6	3-9	134	3	1-11	28	0	0-50	382	6	3-8	192	2	0-5
VICTORIA REGIONAL MEDICAL VICTORIA TEXAS 77901	1	100	1-97	3	0	5-87	13	8	2-42	2	0	0-100	38	3	2-20	45	0	0-18	2	0	0-85	16	0	1-35	61	2	0-11
VILLAGE OAKS REGIONAL HOSP SAN ANTONIO TX 78233	2	0	0-81	.	.	.	10	10	2-48	1	0	0-100	26	11	1-23	11	0	0-45	4	25	1-74	38	8	1-19	21	0	0-39
WADLEY REGIONAL MEDICAL CE TEXARKANA TX 75501	27	19	10-43	19	47	20-64	69	12	2-17	7	0	0-100	195	4	3-10	126	6	2-13	35	0	0-46	247	7	3-9	101	0	0-8
WAGNER GENERAL HOSP PALACIOS TX 77465	4	0	0-76	.	.	.	.	.	.	.	.	.	11	9	0-45	1	0	0-98	.	.	.	21	0	1-28	3	0	0-100
WALLS REGIONAL HOSPITAL CLEBURNE TX 76031	9	11	3-58	7	57	8-70	57	9	3-19	4	0	0-100	135	4	2-10	52	6	1-17	14	0	0-99	123	5	2-10	60	3	0-13
WARD MEMORIAL HOSP MONAHANS TX 79756	8	38	10-71	.	.	.	1	0	0-100	1	0	0-100	14	0	0-87	2	50	0-95	.	.	.	38	3	1-18	3	0	0-96
WEST COKE CO HOSP DISTRICT ROBERT LEE TX 76945	1	0	0-98	.	.	.	.	.	.	.	.	.	2	50	0-99	1	0	0-97	.	.	.	.	.	.	1	0	0-100
WEST COMM HOSP WEST TX 76691	5	40	14-68	5	0	6-75	2	50	0-85	.	.	.	26	4	1-24	8	0	1-54	3	0	0-100	22	0	1-25	8	0	0-56 8
WEST HOUSTON MEDICAL CENTE HOUSTON TX 77082	4	25	2-75	2	0	2-90	11	0	1-45	.	.	.	43	0	1-17	15	7	1-36	1	0	0-100	87	5	1-31	17	0	0-37
WEST PLAINS MEDICAL CENTER MULESHOE TX 79347	4	25	6-82	.	.	.	.	.	.	.	.	.	19	0	0-30	3	0	0-92	.	.	.	5	0	0-84	2	0	0-100
WEST TEXAS HOSP LUBBOCK TX 79401	4	25	5-80	5	20	8-77	6	33	1-62	4	0	0-100	42	5	1-17	11	0	0-48	5	0	0-100	19	0	1-30	20	5	0-40
WICHITA GEN HOSP WICHITA FALLS TX 76301	17	12	5-50	10	20	12-57	57	6	4-19	3	0	0-100	183	6	3-10	144	3	1-21	29	0	0-73	122	7	2-13	121	3	0-7
WILBARGER GENERAL HOSP VERNON TX 76384	10	20	5-61	1	0	0-97	12	8	2-44	1	0	0-100	77	3	2-13	23	0	2-30	3	0	0-100	36	3	1-20	15	0	0-51
WILLACY METHODIST HOSP RAYMONDVILLE TX 78580	4	75	11-97	5	40	7-76				.	.	.	4	25	0-77	2	0	0-94	.	.	.	6	17	0-58			
WILLIAM BEAUMONT GEN HOSP EL PASO TX 79920										.																	
WILSON MEMORIAL HOSP FLORESVILLE TX 78114	7	29	4-66	1	0	1-97	6	17	0-64	.	.	.	32	6	1-22	17	12	1-34	1	0	0-100	35	9	1-29	7	0	0-96
WILSON N JONES MEMORIAL HO SHERMAN TX 75090	12	8	5-54	8	13	15-75	74	3	4-19	4	0	0-100	180	3	3-11	117	4	2-13	26	4	0-50	162	4	2-9	100	1	0-8
WINTER GARDEN HOSPITAL DILLEY TX 78017	3	67	5-87	1	0	2-99	2	0	0-93	1	0	0-100	15	7	0-37	11	0	0-48	.	.	.	8	0	0-55	4	0	0-99

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WOMANS HOSP OF TEXAS INC HOUSTON TX 77054	TX-507*	51	0	0-18	9	0	1-52	.	.		.	.		.	.		.	.		.	.		.	.	
WOOD CO CENTRAL HOSP DISTR QUITMAN TX 75783	TX-508*	352	15	11-21	12	67	14-64	21	19	16-54	8	13	4-60	20	30	9-46	17	29	19-63	19	5	5-42	62	24	13-34
WORTHAM HOSPITAL WORTHAM TX 76693	TX-509*	64	25	10-30	4	75	9-84	9	33	9-63	1	0	0-97	11	27	5-52	2	0	3-91	3	0	1-81	10	40	7-58 8
WYLIE COMMUNITY HOSP WYLIE TX 75098	TX-510	139	19	8-21	1	0	0-99	7	71	6-66	5	40	1-68	8	13	4-58	8	38	13-73	4	25	0-76	23	30	12-49
YETTIE KERSTING MEM HOSP LIBERTY TX 77575	TX-511	253	21	10-21	4	75	5-79	4	25	4-78	7	29	3-60	21	33	9-44	13	62	17-66	12	17	6-54	42	24	11-37
YOAKUM CATHOLIC HOSPITAL YOAKUM TX 77995	TX-512*	321	16	9-19	30	40	11-43	18	22	12-52	10	0	2-50	26	38	10-42	6	17	11-77	8	0	5-61	28	18	9-40
YOAKUM CO HOSP OENVER CITY TX 79323	TX-513*	100	16	9-24	1	100	3-99	1	100	1-97	1	0	0-97	4	0	2-75	6	67	14-81	6	17	5-70	17	12	6-44
YORK PLAZA HOSP AND MED CT HOUSTON TX 77093	TX-514*	166	9	6-18	1	0	0-99	5	40	6-75	3	33	1-81	20	20	7-42	13	8	13-61	6	17	2-64	21	10	4-37
YORKTOWN MEMORIAL HOSPITAL YORKTOWN TX 78164	TX-515	109	17	9-24	4	75	4-77	4	50	6-80	2	0	1-89	12	42	9-57	2	100	4-93	1	0	0-98	12	33	12-61

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WOMANS HOSP OF TEXAS INC HOUSTON TX 77054	.	.		.	.		.	.		.	.		1	0	0-100	1	0	0-100	28	0	0-72	.	.		.	.	
WOOO CO CENTRAL HOSP OISTR QUITMAN TX 75783	4	0	5-80	4	75	14-90	2	50	0-96	.	.		26	4	1-25	10	10	0-48	.	.		53	0	1-15	3	0	0-100
WORTHAM HOSPITAL WORTHAM TX 76693	2	0	1-90	.	.		.	.		1	0	0-100	6	17	0-72	.	.		1	0	0-100	4	0	0-85	.	.	
WYLIE COMMUNITY HOSP WYLIE TX 75098	1	0	0-98	4	75	7-82	5	0	0-82	.	.		16	19	0-35	7	0	0-60	4	0	0-100	11	9	0-49	4	0	0-100
YETTIE KERSTING MEM HOSP LIBERTY TX 77575	13	54	8-58	1	100	2-98	1	0	0-100	.	.		23	4	1-27	14	21	2-40	.	.		14	7	0-42	13	0	0-73
YOAKUM CATHOLIC HOSPITAL YOAKUM TX 77995	3	33	4-86	8	38	12-71	13	15	2-42	.	.		52	6	2-17	19	5	1-31	5	0	0-100	15	7	1-35	12	0	0-43
YOAKUM CO HOSP OENVER CITY TX 79323	8	13	6-66	1	0	0-97	.	.		.	.		9	11	0-54	1	100	0-99	.	.		17	6	0-32	1	0	0-100
YORK PLAZA HOSP ANO MEO CT HOUSTON TX 77093	.	.		2	0	1-89	1	0	0-99	.	.		18	0	0-33	11	18	0-48	1	0	0-100	17	0	0-33	5	0	0-100
YORKTOWN MEMORIAL HOSPITAL YORKTOWN TX 78164	3	33	3-84	3	33	5-86	7	0	1-58	.	.		12	0	0-43	1	0	0-100	1	0	0-100	5	0	0-75	7	0	0-87

*Written Comments Not Submitted.

Alice Physicians and Surgeons Hospital
300 East Third Street, Alice, Texas 78332 | 512 664-4376

October 23, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

RE: 1986 Medicare Mortality Information
Hospital #450353

Dear Dr. Roper:

Thank you for the opportunity to provide input on the Medicare Mortality Statistics for the 1986 period.

The following information for Alice Physicians and Surgeons Hospital is to be attached to the Hospital Specific Report for the 1986 period prior to public disclosure.

Alice Physicians and Surgeons Hospital is a rural 131 bed acute care facility, whose patient mix includes many with major medical and surgical illnesses. We are a full service hospital offering care in general medicine and surgery to a service area population of approximately 40,000 people.

The Medical Staff at Alice Physicians and Surgeons Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and the quality and appropriateness of care. Mortality (death) review is an on-going process of our Quality Assurance program and is an integral part of the monitoring of the health care and patient care delivery system at this hospital. The hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations, formally the Joint Commission on Accreditation of Hospitals. The JCAHO is the nationally recognized accrediting body for hospitals in the United States.

The hospital specific mortality data reports submitted by HCFA have been carefully reviewed by the hospital's Administration, Physician Chairman of the Utilization Review and Quality Assurance Committees and have been verified by the Director of Medical Records.

Our overall percentage of death for all causes is well within the range of predicted mortality rates; in fact, the rate is below the mean (average) percentage of the predicted rates as calculated by averaging the upper and lower limits of this range.

We believe consumers of health care should make informed decisions and, now we can be a resource in that process.

Again, we appreciate the opportunity to respond as part of the release of this data. As has been our practice, our hospital and medical staff will continue to review all aspects of care rendered in the institution and will endeavor to identify opportunities to improve care.

All Saints Episcopal Hospital

AMI Alvin Community Hospital

October 26, 1987

Dr. William Roper, Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

AMI Alvin Community Hospital is an 86-bed facilty offering general acute care including general surgeries. Since the hospital is positioned in a rural environment and serves a population of 40,000 to 50,000 people, we also have an active emergency department.

The hospital specific mortality data reported by HCFA was reviewed by hospital representatives and is considered accurate. While an increasing number of our patients are geriatric, we are pleased to note that through an ongoing Utilization Review, Patient Care Accountability Program (quality assurance) and medical staff peer review process, the data indicates our Hospital to be within the expected mortality ranges for all 16 disease categories. This is a positive reflection of our ongoing efforts to maintain the highest quality of care for each individual patient at AMI Alvin Community Hospital.

Due to the effectiveness of our Patient Care Accountability Program that monitors the management of patient care, our hospital has been able to maintain a consistently high quality level of care. It is through such ongoing programs as the Patient Care Accountability Program and the medical staff peer review process, that we have been able to receive full accreditation by the Joint Commission on Accredition of Healthcare Organizations.

Sincerely,

Wilson Weber
Administrator

Jay M. Lapine
Chief Operating Officer

AMI Bellaire Hospital

October 27, 1987

William L. Roper, M.D.
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on hospital mortality rates for the Calendar year 1986. Since receiving the report dated September 21, 1987, we have had the opportunity to review this data.

AMI Bellaire Hospital is a 349 bed acute care and psychiatric hospital serving the needs of a small elderly community within the Houston area. In reviewing the data that you supplied us, we feel that it is necessary to point out that a very large part of our patient population is extremely elderly and come to us from area nursing homes. We have identified through our reviews that over 50% of our Medicare deaths in calendar year 1986 were in the 81 to 107 year old category.

The two areas that you show our hospital as being outside the range of predicted mortality rates are pulmonary disease and renal disease. This is predictably high considering our particular patient mix during the reporting period. During this period, we did have a large number of extremely elderly patients admitted from area nursing homes with multiple medical problems involving these two categories. Frequently, their admission was substantially late in the course of their condition. This situation was recognized through the ongoing quality and appropriateness of care audits that are done by the hospital to assure our patient's the optimum of care.

Again, I thank you for the opportunity to address these issues.

Sincerely,

Jay M. Lapine
Interim Chief Executive Officer

/w

Coastal Bend Hospital
1711 West Wheeler Alice, Texas 78332 512 668-8511



COMMENTS ON THE HCFA MORTALITY DATA
AMI COASTAL BEND HOSPITAL
MEDICARE PROVIDER #45-0605

We agree with HCFA Administrator, William Roper, M.D., that these statistics are intended to be used in hospital quality assurance programs. We recognize that mortality rates, by themselves, do not measure quality, but are used to focus indepth peer review.

The governing board, medical staff and management team of Coastal Bend Hospital are committed to providing quality patient care. We constantly monitor the care rendered to our patients via quality assurance, utilization review and Joint Commission of the Accreditation of Health Care Organization's standards and monitoring programs. Above and beyond these programs, we have implemented our own system, the Patient Care Accountability Program to assure the highest quality of patient care.

Patients that expired up to 30 days after they were discharged from the hospital were included in these statistics. The majority of patients who expired after they were discharged from Coastal Bend Hospital, passed away for reasons that were unrelated to the care given on the diagnosis.

An American Medical International, Inc. Health Care Co.

AMI Denton Regional Medical Center

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Attention: William L. Roper, M.D.
Administrator

Dear Dr. Roper:

Thank you for the opportunity to comment on the mortality statistics for calendar year 1986.

AMI Denton Regional Medical Center is a 195 bed acute care facility serving patients with a variety of medical and surgical illnesses. We offer care in the specialty areas of cardiac catheterization, dialysis, orthopedic services and obstetrics, as well as general medicine and surgery.

All cases are reviewed as an ongoing process of our Quality Assurance program.

Although our primary focus of review is quality of care for all patients, we are pleased to note that the statistical summary of the HCFA Mortality Data Release demonstrates that the mortality rate for this facility is well within the predicted range. In fact, our mortality rate for all causes is in the lower half of the predicted range.

Thank you for the opportunity to append this comment to our data.

Sincerely,

Don S. Ciulla
Chief Executive Officer

AMI Fort Bend Community Hospital

October 22, 1987

Department Health & Human Services
William Roper, M.D.
Administrator

RE: Mortality Data Response

We appreciate the opportunity to provide input on the Mortality Data Release for 1986. The Medical Records of those patients who expired during 1986 were monitored by our Medical Staff Committees in our facility on an ongoing basis, for appropriateness of care.

After review of the records of the patients noted on the Mortality Data Release the following was noted;

Of the thirty-four (34) patients included in the Mortality Data, fifteen (15) of the patients and/or family members requested that no extensive life saving measures take place, as well as signed a Do Not Resuscitate Consent.

Four (4) of the patients noted on the Mortality Data had secondary diagnosis of some form of Cancer. These patients were found to have expired from underlying conditions caused by the Cancer.

Two (2) patients noted on the Mortality Data were transferred into our facility from Nursing Homes with very poor prognosis.

Again, we appreciate the opportunity to present this response.

Sincerely,

Frederick R. Grates
Executive Director

3803 FM 1092 @ Highway 6 Missouri City, Texas 77459 713 499-4500

AMI Heights Hospital

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

AMI Heights Hospital is a 213 bed short-term acute care facility, fully accredited by the Joint Commission on Accreditation of Health Care Organization, offering medical services in cardiology, endocrinology, gastroenterology, hematology, internal medicine, neurology, and oncology. Obstetrical, gynecological, and pediatric services are also available. Surgical services offered by the hospital include general surgery, neurosurgery, ophthalmology, orthopedic, otolaryngology, plastic surgery, tumor, and urology. Additionally in an effort to meet the needs of our patients, the hospital has developed a Skilled Nursing Unit to provide services for patients who no longer need acute hospital care.

The hospital specific mortality data reported by HCFA has been reviewed by hospital representatives and is considered to be accurate. We are pleased to note that AMI Heights Hospital did not exceed the expected mortality ranges for any of the 16 diagnostic categories.

The Medical Staff of AMI Heights Hospital, as has been their practice, will continue to review all mortality cases for quality and overall care provided for the individual patient. We believe that our monitoring system provides us with a continuous feedback mechanism to assist in identifying opportunities to improve care.

Thank you for the opportunity to present this response.

Sincerely,

Brian S. Barbe

Brian S. Barbe
Executive Director

BSB:bp

P.O. Box 7497, 20th and Ashland, Houston, Texas 77008-3994 713 861-6161

AMI Katy Medical Center

October 27, 1987

HealthCare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Medicare Provider Number = 450706

Dear HCFA Administrator:

The confidential release of the mortality data to us prior to publication is greatly appreciated. An ad-hoc committee consisting of our Chairman of Medical Staff Utilization Review Committee, Chief Operating Officer, Director of Medical Records and myself has reviewed and validated the data. The data is consistent with our records as all mortalities are reviewed by the Medical Staff clinical departments for appropriateness and quality of care. It is noted that our 17% mortality rate is well within the predicted 11 to 21%.

The review of the mortality data elicited the following pertinent information:

a) 29% of the mortalities were patients with known terminal disease and were of a "Do Not Resuscitate" status.

b) The average age of the deceased patient was 80 years old.

c) It is to be noted that 40% of the mortalities were patients admitted to the hospital from nursing homes with the expected less than optimum health for their age.

d) Our highest mortality rate by diagnostic category, sepsis, after review, indicated that the 53% mortality (predicted range 19 to 67%) rate, is on the higher end. However, this reflects the associated co-morbid (co-existing terminal) conditions of these patients.

We were pleased to note that we were within the predicted mortality range for all diagnostic categories.

Sincerely,

Warren W. Wilkey
Executive Director

cc: Dr. Mark Bing, Chmn UR/MR Committee
D. Klein, Chief Operating Officer
S. Burch, Director of Marketing

5602 Medical Center Drive Katy, Texas 77450 713 392-1111

AMI Medical Arts Hospital

October 19, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland

Dear Dr. Roper:

In response to the Health Care Financing Administration's release of hospital mortality data, AMI Medical Arts Hospital, Provider Number 450696, agrees with your findings, in that our records indicate a zero percent mortality rate in the diagnostic categories selected for review. We also recognize that this information is not necessarily an indication of quality of care provided by healthcare institutions.

At AMI Medical Arts Hospital in Dallas, Texas, our medical staff monthly performs an ongoing review of mortality cases and quality of care. Our hospital and its' medical staff support the principle of communicating appropriate and meaningful quality of care information to consumers. The hospital welcomes the opportunity to discuss quality of care we provide to our consumers.

If additional information is needed, please contact me.

Sincerely,

Phillip L. Coppage

Phillip L. Coppage
Executive Director

PLL:ja

Attachment

cc: Kenn George
Mike Sullivan
Rita McBride

6161 Harry Hines Boulevard. Dallas. Texas 75235 214 688-1111

AMI Park Plaza Hospital

October 26, 1987 Medicare provider # 45-0659

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington D.C. 20201

Subject: HCFA Hospital Specific Mortality Information

Dear Dr. Roper:

Thank you for the opportunity to provide input on the mortality statistics for the period between October 1, 1984 and September 30, 1986.

AMI Park Plaza Hospital is a licensed, 508-bed general acute care facility offering a full range of health care services. It offers outpatient and inpatient care in 43 medical specialties with over 750 physicians on its Medical Staff.

The Medical Staff at Park Plaza conducts a review of the medical record of every patient who expires at the hospital as a part of its overall quality assurance program. Each case is reviewed according to the disease process for which the patient was admitted and the overall treatment and care the patient received for his or her medical condition. In addition, the Medical Staff and hospital have implemented ongoing quality assurance and peer review process that is applied to all patients who receive care at this facility.

The hospital specific mortality data reported by HCFA have been reviewed by the Physician Chairman of the Quality Assurance and Utilization Review Committee, Hospital Administration, the Director of Medical Records, and the Director of the Patient Care Accountability Program. This group verified that the mortality rates reported were all either well within the range of predicted mortality rates for the hospital with the exception of two categories that were slightly below this range.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

The following provides some comments regarding discrepancies that were identified when validating the data:

- The HCFA Mortality Data indicates that a total of 1768 medicare patients were admitted to Park Plaza Hospital in 1986. The data also indicates that 158 of these patients expired within 30 days of admission. Of those that expired 122 died while still a patient in the hospital, while 36 died after discharge. Our own records indicate that a total of 2758 medicare admissions occured in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries. Our records also indicate 128 patients died while still in the hospital, 29 patients died after discharge, and 1 patient was verified as still alive more than 30 days following discharge.

- The review of the patient charts of those 128 individuals who died while still in the hospital indicated that 86 or 67% were in high risk catagories and death was an expected outcome. The remaining 42 or 33% had chronic conditions most of which having significant comorbidities and death was imminent.

- It is difficult to verify the information on the 36 patients which the HCFA data indicates died after discharge since the information concerning death after discharge was not reported in the patient's medical record. Six of the 36 patients which HCFA's data indicated dying after discharge did however die while still a patient in the hospital. One of these patients was verified as alive at discharge and was still alive 30 days after the admission.

- A breakdown of those 29 patients who were discharged indicates that 20 were discharged to home, 6 were discharged to nursing homes, and 3 were discharged to a skilled nursing facility. All 29 of these patients were chronically ill or had a terminal illness.

(Attached is an analysis of reporting errors and a corrected patient listing.)

The quality of patient care and medical services provided is an essential component in the operating philosophy of our hospital. The Medical Staff at Park Plaza will utilize information provided by HCFA as another information source into its quality assurance program understanding that each patient's care must be looked at on an individual basis.

Again, thank you for the opportunity to present this response.

Sincerely,

Carl W. Fitch

Carl W. Fitch
President

WMV/mf 0102

Provider # 450659

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital'	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	7	6	9	4
CE -- Cerebrovascular Accidents	14	1	15	0
GC -- Gastrointestinal Catastrophes	6	0	6	0
GI -- Gastrointestinal Disease	7	1	7	1
GU -- Urologic Disease	4	3	4	3
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	1	1	2	0
HM -- Severe Chronic Heart Disease	8	3	9	2
HS -- Severe Acute Heart Disease	10	0	10	0
ME -- Metabolic/Electrolyte Disturbances	7	3	8	2
OP -- Orthopedic Disorders	1	1	1	1
PN -- Pulmonary Disease	24	2	24	2
RN -- Renal Disease	2	1	2	1
SE -- Sepsis	8	1	8	1
TR -- Severe Trauma	0	0	0	0
OP -- Ophthalmalogic Disease	0	1	0	0
UN -- Other Diagnoses	23	12	23	12
Total -- All Categories	122	36	128	29
	158		157	

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30 days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

AMI Parkway Hospital
Medicare Provider No. 450544

We feel our success at achieving a mortality rate within the predicted range is due in no small part to the extensive Quality Assurance Program here at AMI Parkway. The Hospital has had a very effective monitoring system which includes a Medical Staff Committee review of medical records of every patient who expires at the Hospital. Mortality review is an integral part of the patient care accountability program in place at the Hospital which assures the highest standard of care.

This statistical achievement is even more remarkable when you consider the following information:

1. Over 75% of our Medicare patients come to our Hospital through our Emergency Room, many in critical condition.

2. The average age of the patients in the mortality study was 80.

3. Because of the high number of nearby Nursing Homes, which is a major source of admissions, and because of an extensive admission screening program, the intensity of illness of our patients prior to admission is higher than average.

AMI Parkway Hospital scored within the predicted range in every category but one, Sepsis (SE). In that category, we had one case higher than the range. Of the seven cases, 4 were either unconscious or comatose when admitted, while the other three were admitted through the Emergency Room in either critical or serious condition. The care provided these patients met every standard of care. As part of their regular review, the Texas Medical Foundation reviewed some of these medical records and found them to meet their criteria as well.

In sum, while we feel the statistics support the quality care at AMI Parkway Hospital, we are always striving to continually improve in every way.

0325TP:mh

AMI Riverside Hospital, Inc.

COMMENTS ON THE HCFA MORTALITY DATA
RIVERSIDE HOSPITAL, INC.

The data presented by HCFA indicates that a total of 672 Medicare patients were admitted to Riverside Hospital, Inc. in 1986. Eighty-six (86) Medicare patients were identified by HCFA as mortality cases at Riverside Hospital, Inc. After analyzing the data, it is determined that twelve (12) of these patients did not expire at Riverside Hospital. Our own records indicated that 1,100 Medicare admissions occurred in calendar year 1986. Discrepancies between the figures are presumably due to multiple admissions of individual beneficiaries to different hospitals. Based upon the HCFA mortality model and billing procedures, we have no way of verifying the number of Medicare patients treated at Riverside Hospital as calculated by HCFA.

Further analysis of the data revealed discrepancies in patient ages and Social Security numbers. The changes are submitted to HCFA for correction. Using the corrected data from our analysis the overall mortality rate for Riverside Hospital is calculated at 11 percent. All of the mortality cases as classified by the HCFA diagnostic categories are within the predictable mortality ranges determined by HCFA. Fifty-two (52) cases or 72 percent of the patients at Riverside Hospital had high risk factors of mortality. Twelve (12) cases were identified as having unknown mortality diagnostic categories.

The governing board, medical staff, and management team of Riverside Hospital are committed to providing quality patient care. We constantly monitor the care rendered to our patients via quality assurance, utilization review, and Joint Commission of the Accreditation of Health Care Organization's standards and monitoring programs. Above and beyond these programs, we have implemented our own system, the Patient Care Accountability Program, to issue the highest quality of patient care.

13725 Farm Road 624 Corpus Christi, Texas 78410 512 387-1541

HOSPITAL ID NUMBER - 450131

PATIENTS NOT EXPIRING AT THIS FACILITY

PATIENT ID NUMBER (HIC)	SURNAME (FIRST 6 LTRS)	DIAGNOSTIC CATEGORY	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	PRINCIPAL DIAGNOSIS	PRINCIPAL PROCEDURE
[redacted]		PN	069	F	01/06/86	01/22/86	02/07/86	4908	
		PN	087	M	05/31/86	06/11/86	06/17/86	486	
		RN	094	F	10/18/86	10/24/86	10/30/86	59010	
		TR	091	F	09/23/86	10/03/86	10/06/86	82021	7935
		UN	095	F	02/11/86	02/19/86	03/07/86	4542	
		UN	073	M	11/29/86	11/30/86	11/30/86	2512	
		UN	081	F	08/22/86	08/27/86	09/01/96	2639	
		CA	072	M	07/28/86	08/14/86	08/20/86	1625	3327
		GI	090	F	10/17/86	10/18/86	11/07/86	5693	
		HL	072	F	11/30/86	12/04/86	12/09/86	4279	
		HM	089	M	11/08/86	11/26/86	11/27/86	4280	3491
		HM	087	M	01/16/86	01/22/86	01/31/86	40211	

TX 51.1

HOSPITAL ID NUMBER - 450131

CORRECTIONS TO HCFA MORTALITY STATISTICS

PATIENT ID NUMBER (HIC)	SURNAME (FIRST 6 LTRS)	DIAGNOSTIC CATEGORY	AGE	SEX	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	PRINCIPAL DIAGNOSIS	PRINCIPAL PROCEDURE
[redacted]		PN	077	F	06/09/86	06/14/86	06/14/86	5119	3491
		PN	074	F	12/13/86	12/16/86	12/16/86	486	
		UN	065	M	04/07/86	04/11/86	04/11/86	4372	
		CA	080	M	03/23/86	04/12/86	04/12/86	1623	
		CE	095	F	05/24/86	06/07/86	06/07/86	4349	
		GI	075	F	07/03/86	07/24/86	07/24/86	5768	5122

TX 51.2

KEY: Underlined data indicates the corrected information.

AMI Twelve Oaks Hospital

October 20, 1987

Dr. William L. Roper
Administrator
Health Care Financing Administration
P.O. Box 26676
Baltimore, MD 21201

RE: Provider #450423

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on hospital mortality rates for Twelve Oaks Hospital for the year 1986. Since receiving the report, Twelve Oaks Hospital staff has had the opportunity to review the data.

The attached information for Twelve Oaks Hospital is to be attached to the Hospital Specific Report for the year 1986 prior to public disclosure.

Twelve Oaks Hospital is a 336 bed general care acute facility, whose case mix includes many patients with major medical and surgical illnesses. Twelve Oaks is a full service medical center offering care in specialty areas of cardiology, ophthalmology, oncology, major orthopedic services, rehabilitative medicine as well as general medicine and surgery. Also, two areas, oncology and immuno-suppresive disease, specifically have shown a higher percentage of growth in our facility.

The Medical Staff at Twelve Oaks Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this Hospital. The Joint Commission on Accreditation of Hospitals and American Medical International, Inc., have bestowed approval on the Quality Assurance program and the peer review process that is performed.

The hospital specific mortality data reported by HCFA has been carefully reviewed by the hospital administrator, the Chief of the Medical Staff, the Executive Board, Chairman of the Medical Records/Utilization Review/Quality Assurance Committee, and the Director of Medical Records. Our overall percentage of deaths is much less than the predicted mortality rate. This data release

includes cumulative data for 1986. This data release is by Diagnostic Related Groups (DRG). As we have stated, this facility reviews individual cases for quality of care and this is conducted in an ongoing fashion, not just when statistics such as mortality data is released.

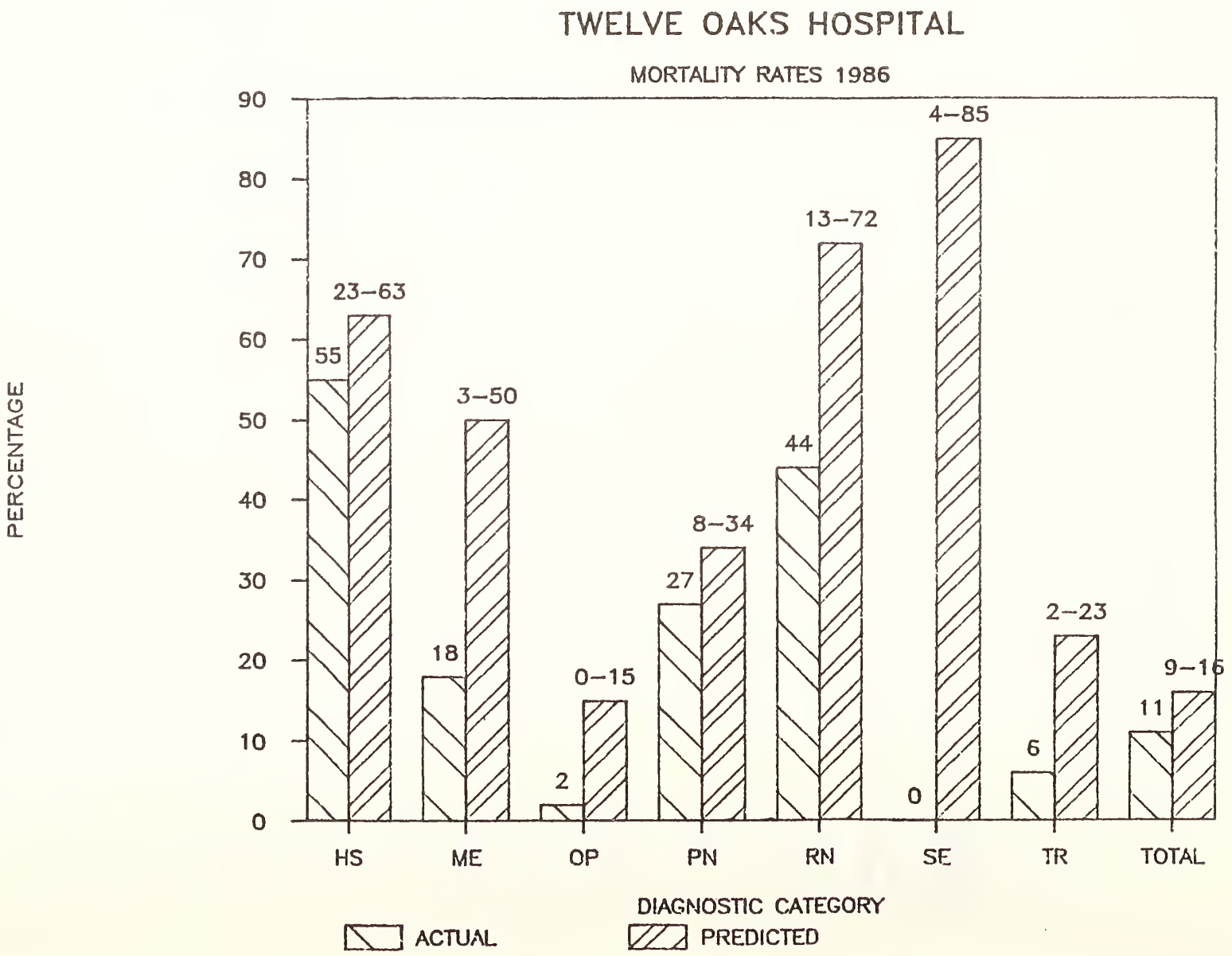
Thank you for the opportunity to present this response.

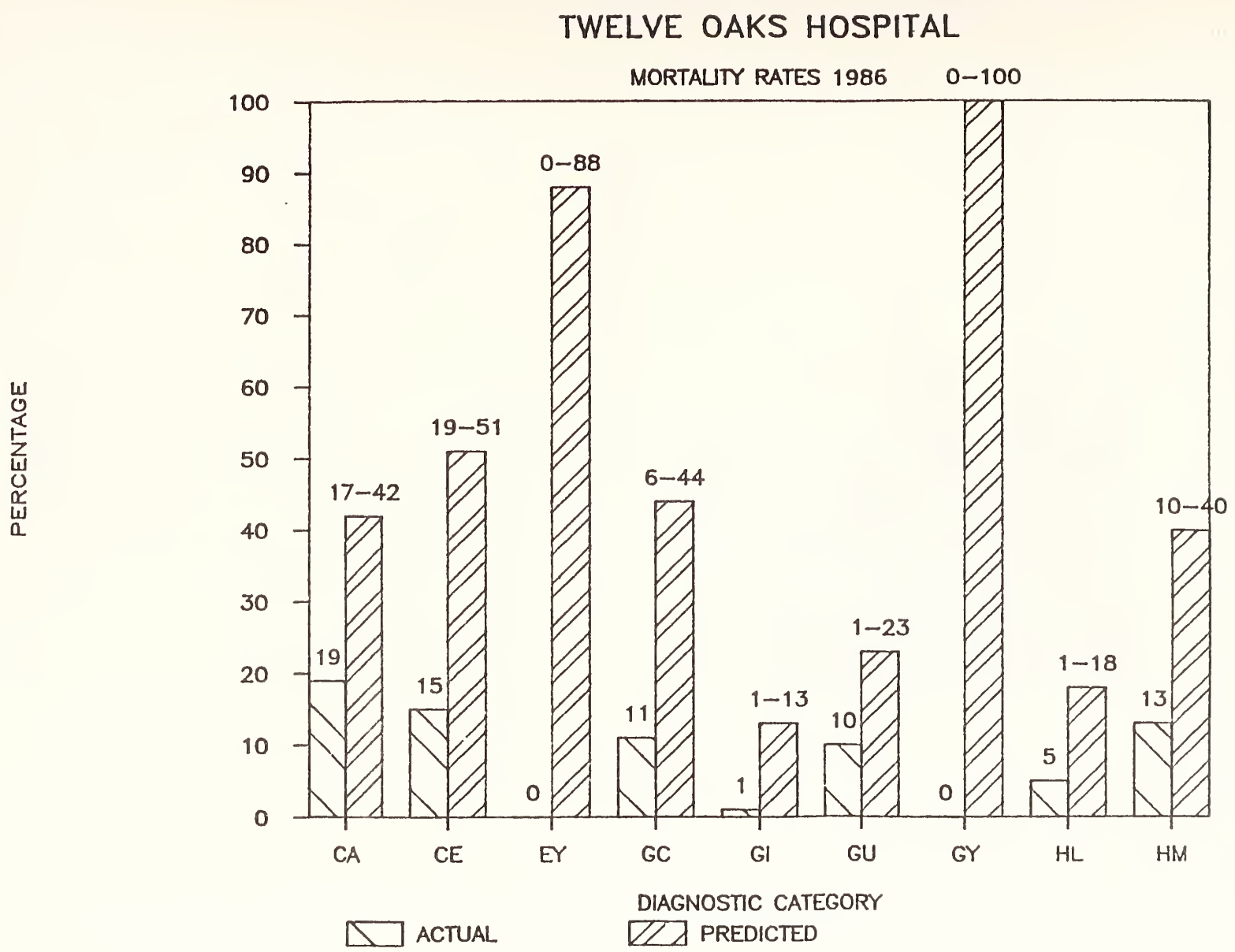
Sincerely,

Walter J. Ornsteen
Executive Director

WJO/nlg

attachment


TWELVE OAKS HOSPITAL
MORTALITY RATES 1986
PERCENTAGE
90
80
70
60
50
40
30
20
10
0
55
23–63
18
3–50
2
0–15
27
8–34
44
13–72
0
4–85
6
2–23
11
9–16
HS
ME
OP
PN
RN
SE
TR
TOTAL
DIAGNOSTIC CATEGORY
ACTUAL
PREDICTED

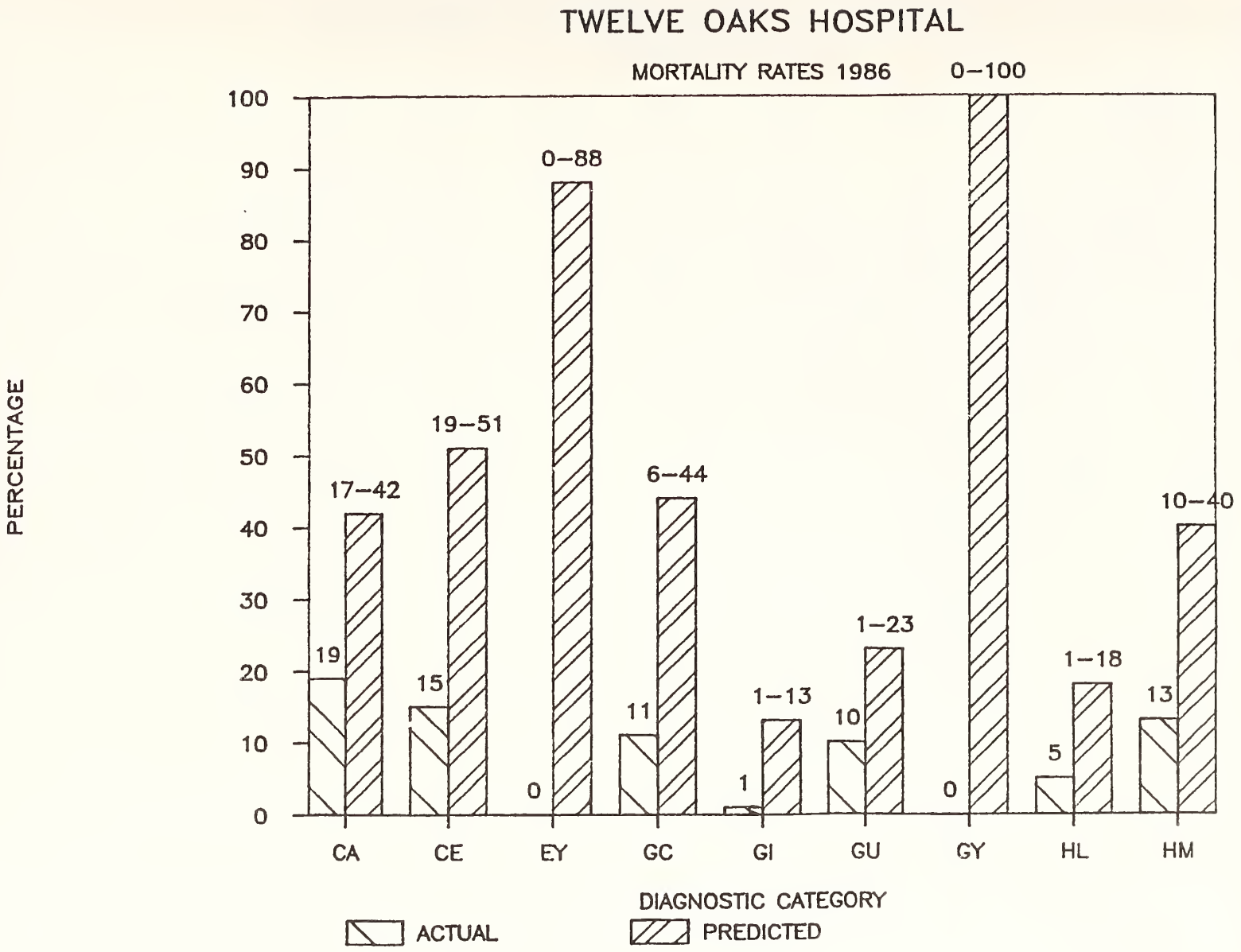

TWELVE OAKS HOSPITAL
MORTALITY RATES 1986
PERCENTAGE
100
90
80
70
60
50
40
30
20
10
0
0–100
0–88
19–51
17–42
6–44
10–40
1–23
1–18
1–13
19
15
0
11
1
10
0
5
13
CA
CE
EY
GC
GI
GU
GY
HL
HM
DIAGNOSTIC CATEGORY
ACTUAL
PREDICTED

TWELVE OAKS HOSPITAL
MORTALITY RATES

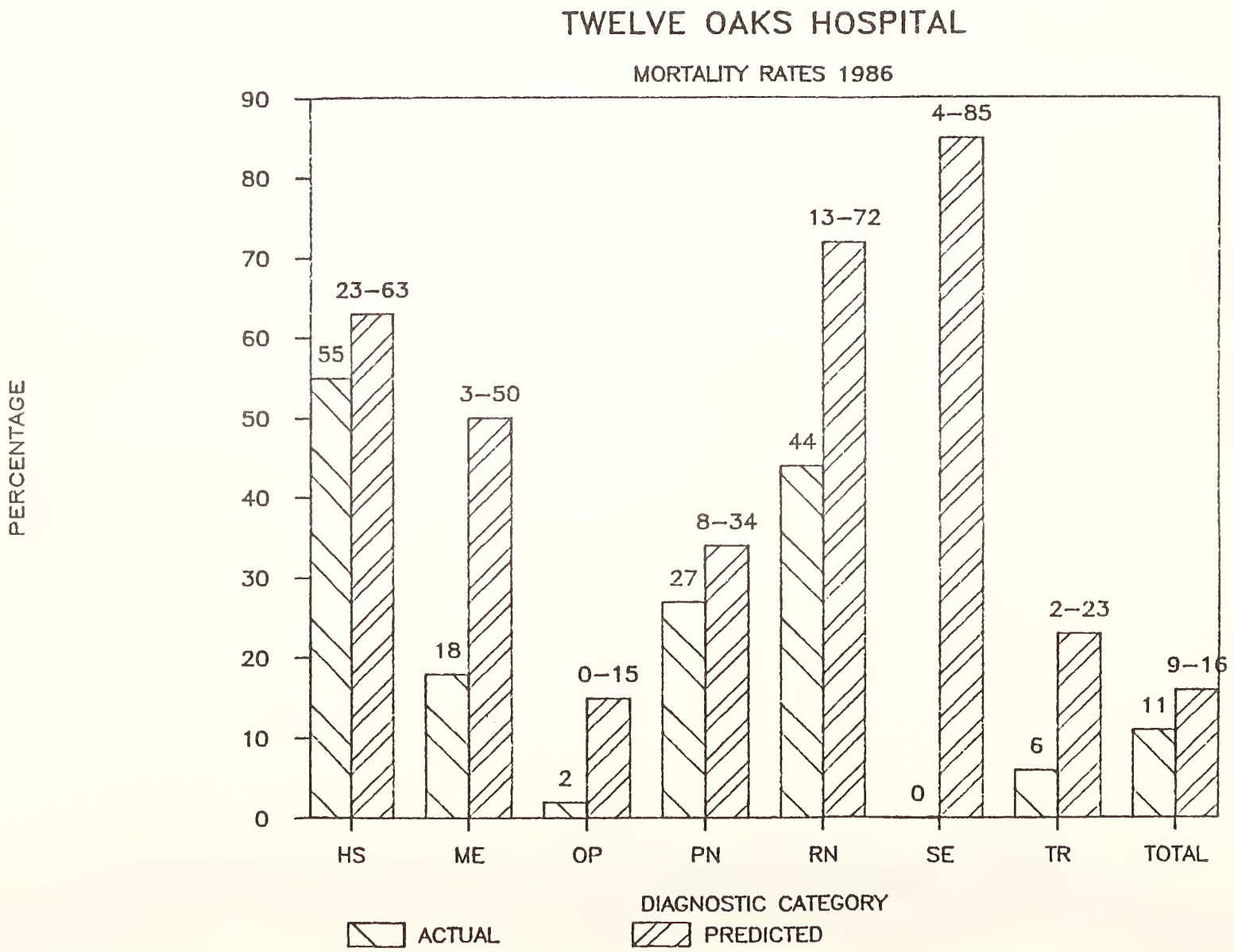
ABBREVIATION CHART

CA	- CANCER
CE	- CEREBROVASCULAR ACCIDENTS
EY	- OPTHALMOLOGIC DISEASE
GC	- GASTROINTESTINAL CATASTROPHES
GI	- GASTROINTESTINAL DISEASE
GU	- UROLOGIC DISEASE
GY	- GYNECOLOGIC DISEASE
HL	- LOW-RISK HEART DISEASE
HM	- SEVERE CHRONIC HEART DISEASE
HS	- SEVERE ACUTE HEART DISEASE
ME	- METABOLIC/ELECTROLYTE DISTURBANCES
OP	- ORTHOPEDIC DISORDERS
PN	- PULMONARY DISEASE
RN	- RENAL DISEASE
SE	- SEPSIS
TR	- SEVERE TRAUMA

TX 5 2.5


TWELVE OAKS HOSPITAL
MORTALITY RATES 1986
PERCENTAGE
100
90
80
70
60
50
40
30
20
10
0
17–42
19
19–51
15
0–88
0
6–44
11
1–13
1
1–23
10
0–100
0
1–18
5
10–40
13
CA
CE
EY
GC
GI
GU
GY
HL
HM
DIAGNOSTIC CATEGORY
ACTUAL
PREDICTED

TX 52.6


TWELVE OAKS HOSPITAL
MORTALITY RATES 1986
PERCENTAGE
90
80
70
60
50
40
30
20
10
0
55
23–63
18
3–50
2
0–15
27
8–34
44
13–72
0
4–85
6
2–23
11
9–16
HS
ME
OP
PN
RN
SE
TR
TOTAL
DIAGNOSTIC CATEGORY
ACTUAL
PREDICTED

TWELVE OAKS HOSPITAL
MORTALITY RATES

ABBREVIATION CHART

CA	- CANCER
CE	- CEREBROVASCULAR ACCIDENTS
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RN	- RENAL DISEASE
SE	- SEPSIS
TR	- SEVERE TRAUMA

AMI

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to provide input on the mortality statistics of Westbury Hospital for the calendar year 1986. The Director of Medical Records has validated the accuracy of the data and our Medical Staff has reviewed the mortality statistical data and the specific medical records.

Westbury Hospital is a 123-bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. The Medical Staff at Westbury Hospital performs an intensive review of the medical record of every patient who expires at this facility regarding medical managemant and overall care. Mortality review is an ongoing process of the Quality Assurance program and we believe that this monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

While we have confidence in the overall methodology of the mortality data, it is of concern to us that these statistics reflect six deaths (15% of the total mortalities) which occurred outside our facility where we have no control over care rendered (i.e., in nursing homes). I believe that this factor may impact an institution's mortality rates and, in some situations, significantly enough that the public will get an incorrect image of the hospital based solely on the data. In and of itself, the mortality data does not necessarily depict accurately the quality of care rendered at a hospital, but may be interpreted by the public as so.

We at Westbury Hospital welcome the opportunity to answer any questions regarding the quality of care provided to our patients.

Respectfully,

Mel Bishop
Executive Director

tm

5555 Gas[illegible]

ANGLETON-DANBURY GENERAL HOSPITAL
132 Hospital Drive, Angleton, Texas 77515
COMMENTS ON THE HCFA MORTALITY DATA
October 14, 1987

Data Verification

The data used by HCFA indicate that a total of 64 Medicare patients admitted to Angleton-Danbury General Hospital died within 30 days of admission. Of these, 46 died while still a patient of the hospital, while 18 died after discharge.

Review of the hospital's data indicates that 656 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to the same or different hospitals. Review of our own records also indicate that a total of 70 Medicare patients died within 30 days of admission. Of these 18 died after discharge. It is impossible to determine the percentage of the 18 patients dying after discharge who might in fact have been alive, as information ocncerning death after discharge is not included in the patient's medical record, nor is it readily available to the hospital.

Interpretive Remarks

In all of the diagnostic categories, the hospital's actual mortality rate is within the range of HCFAs predicted mortality rate. After correcting the errors in the recording of deaths, the hospital's actual mortality rate remains within the range of the mortality rate predicted by HCFA.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

ATTACHMENT 5

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	2	-	2	-
CE -- Cerebrovascular Accidents	4	3	5	2
GC -- Gastrointestinal Catastrophes	0	1	0	1
GI -- Gastrointestinal Disease	3	-	3	3
GU -- Urologic Disease	1	2	1	2
GY -- Gynecologic Disease	-	-	-	-
HL -- Low Risk Heart Disease	2	1	2	1
HM -- Severe Chronic Heart Disease	4	2	4	2
HS -- Severe Acute Heart Disease	2	-	2	-
ME -- Metabolic/Electrolyte Disturbances	1	1	2	-
OP -- Orthopedic Disorders	-	-	-	-
PN -- Pulmonary Disease	11	3	12	2
RN -- Renal Disease	3	-	3	-
SE -- Sepsis	4	2	4	2
TR -- Severe Trauma	1	-	1	-
OP -- Ophthalmalogic Disease	-	-	-	-
UN -- Other Diagnoses	8	3	11	2
Total -- All Categories	46	18	52	18

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

BAPTIST HOSPITAL
OF SOUTHEAST TEXAS

Selman Clark
President

October 27, 1987

Harvey Brooks
6325 Security Boulevard
Meadows East Building
Room 2D2
Baltimore, Maryland 21207

Dear Mr. Brooks:

The following information for Baptist Hospital of Southeast Texas in Beaumont, Texas, **Medicare Provider 45-0346**, is to be attached to the Hospital Specific report for the period October 1, 1984, through September 30, 1986, prior to public disclosure.

Baptist Hospital of Southeast Texas is a licensed 387 bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. We are a full-service medical center offering care in specialty areas such as oncology, open-heart surgery, major orthopedic services, as well as general medicine and surgery.

The Director of Medical Records has validated that, with minor exceptions, the data is accurate. Our hospital medical staff committees monitor every death in our facility on an on-going basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet or exceed quality care standards.

Your data indicates that Baptist Hospital of Southeast Texas has an overall mortality rate of 13%, falling in mid-range of predicted rates. It is also to be noted that Baptist Hospital of Southeast Texas, with one exception, falls within the mid-range of predicted mortality rates for all diagnostic categories studied.

For this category, Pulmonary Diseases, the mortality data reported has been carefully reviewed with the following findings:

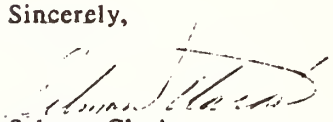
The 27% mortality rate reported represents 37 of the 147 medicare patients treated in this category. It should be noted that the median age of these 37 patients was 77.

Out of the 37 deaths reported 31 of these patients were, at the time of their hospitalization, identified as having terminal conditions.

The remaining 6 patients all had complex medical co-morbidities, including septic shock, intracerebral hemorrhage, renal insufficiency, massive CVA, and dehydration.

Thank you for the opportunity to more fully analyze the data and present our findings and response.

Sincerely,



Selman Clark
President

SC:lm

BMHS

Baptist Memorial Hospital System 111 Dallas St. • San Antonio, Texas 78286-0401 • (512) 222-8431

M. Derick Boldt, M.D.
Vice President of
Medical Affairs

October 20, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

The Baptist Memorial Hospital System (BMHS) in San Antonio, Texas is very pleased to have the opportunity to respond with comments on the Mortality Study, which is to be publicly released in December of 1987.

Our Hospital System is an 85 year old institution comprised of three geographically distant hospitals, totaling 1,205 beds and operating under one Medicare Provider number. A part of our institution's quality assurance program includes review of every death which occurs within the hospital and using the information gleaned from the review to make any changes necessary to improve patient care.

BMHS has devoted its efforts to taking care of the very sick patient. As a consequence, one might expect our mortality rates to be higher than hospitals which do not care for severely ill patients. Our hospitals participate in the care of the most severely ill cancer patients, terminally ill heart and kidney patients, and large numbers of patients who have suffered from strokes. The Baptist Hospital System has one hundred thirty (130) critical care beds (MICU, SICU, CCU, telemetry and intermediate intensive care) as well as two Cardiac Catheterization Laboratories which perform a large number of diagnostic heart studies as well as surgical suites where over 250 open heart surgeries are performed yearly. The severity of illness in our patients is extremely high and we are very pleased to see that your studies indicate that the actual mortality rates for the 16 selected categories of study are well within the range of predicted mortality rates. The HCFA Study also indicates that the average age at the time of death in our institution is 78.55

years. When comparing this with the average life expectancy in the United States of 74.7 years and the average life expectancy in the state of Texas of 73.6 years, we feel that the figures speak for themselves.

In attempting to analyze this study of mortality more thoroughly, we developed a computer program to analyze the deaths which occurred in our hospital system from the admissions of 1986 as stated in the Federal Register of August 17, 1987. After receiving this mortality study from HCFA, we realized that the study was based on hospital discharges in 1986 and not admissions. The Federal Register of August 17, 1987 which gave notice to this mortality study listed the word "Admissions" on 25 different occasions but the wording "Date of Discharge" is not mentioned in the technical description of methodology. As a consequence of such misleading information, we cannot appropriately respond to these figures within the 30 day comment period. Our computer analysis programs are in the process of being reprogrammed to analyze the discharge data rather than the admission data. It is requested that the Health Care Financing Administration reconsider the length of the comment period on this mortality study and on all studies to be released in the future. A true analysis with time to comment normally would require a minimum of 60 days and preferably, 90 days.

According to the data HCFA provided in our specific mortality study, 19% of the total deaths occurred outside of the hospital and we have limited sources to know whether these deaths were associated with the illness of the last hospital admission or not. We can only assume that a number of these deaths were a result of events unrelated to the patient's illness on the last hospital admission prior to death.

Our specific data shows that the unknown (UN) cases (consisting of diagnoses other than the 16 which were listed on the summary page) accounted for 29% of the total cases studied. One would think it would be prudent reporting by HCFA to summarily classify 29% of the total cases studied. This is statistically such a large number of total cases that it cannot be ignored.

The Federal Register of August 17, 1987 on page 30742 states that: "Specifically we intend that this information be used by consumers in making decisions about their health care and by hospitals in improving performance and internal management". Most hospitals would agree with the intent of this statement. However, on page 30743 of the Federal Register of the August 17, 1987 notice, you state: "Thus, a difference between a hospital's actual and expected mortality rates cannot be definitely construed as reflecting especially high or low quality of care". My personal experience with consumers and with the medical literature indicate that consumers are concerned about the quality of care and the average citizen will use the actual mortality rate of the hospitals as a comparison to make his or her decisions as to where medical care is to be received. As a

result, a scenario may develope in which "Mr./Ms. Average Citizen" developes severe chest pains with radiation down the arm. "Mr./Ms. Average Citizen" is intelligent enough to know that he or she is experiencing the onset of a heart attack.

Consequently, he/she reviews the data obtained from the local newspaper which shows that hospital X has a very low mortality rate for severe acute heart disease as compared to hospital Y. He/she consequently goes to hospital X immediately for treatment of a heart attack only to find that hospital X does not have a coronary care unit, cardiac catheterization laboratory, coronary heart team, nor heart surgeons which can perform open heart surgery. He/she then is referred to a hospital which is a tertiary care center and loses valuable time getting to the cardiac catheterization laboratory where the partially occluded coronary artery can be opened before the heart muscle becomes severely damaged. As a result of the delay in the transfer, he/she developes severe damage to the heart muscle which increases his/her chance of dying in the institution to which he/she was referred.

Unfortunately, this scenario will take place across the entire country when the citizens of this country begin comparing mortality rates in hospitals. We can only see these types of studies leading to increased cost of medical care for the Medicare beneficiaries in this country and a decrease in the quality of care.

The Baptist Memorial Hospital System is proud of its statistics in all aspects of medicine especially since the Medicare population of our hospital admissions constitute 44% of all admissions. We will endeavor to continue to provide quality care for all our patients whether they be Medicare or otherwise.

Sincerely,

M. Derick Boldt, M.D.

M. Derick Boldt, M.D.
Vice President - Mecical Affairs

MDB:mb

BAYLOR MEDICAL CENTER AT ENNIS

803 West Lampasas Street
Ennis, Texas 75119.
(214) 875-9071

Ronald P. Hudspeth
Executive Director

October 27, 1987

William S. Roper, M.D.
Administrator
Health Care Financing Administration
DEPARTMENT OF HEALTH AND HUMAN SERVICES
P. O. Box 26676
Baltimore, Maryland 21201

Re: Provider # 45-0349

Dr. Roper:

We appreciate the opportunity to respond to the statistics that the Health Care Financing Administration (HCFA) has compiled from Medicare billing records. Our Medicare patients are important to us, and we welcome the opportunity to discuss their care.

Baylor Medical Center at Ennis is an acute care, full service, not-for-profit hospital and a community resource. We take great pride in providing the quality of care the community expects from a Baylor Medical Center. We feel as though the members of our community support their hospital and are confident of the quality of care delivered. Approximately seven of every ten Ennis residents turn with confidence to the Baylor Health Care System to fulfill their medical and physical needs.

Baylor's commitment to quality is tangible, Baylor Medical Center at Ennis completed a $3.4 million expansion project in 1982. Additionally, we have worked with the Board of Trustees, all of whom are Ennis residents, the medical staff, the nursing staff and administrative personnel to continue to improve the quality of care. To that end, Baylor Medical Center at Ennis now offers surgery, labor/delivery, radiology, pharmacy, physical and respiratory therapy, intensive and critical care units, cardiopulmonary services, clinical laboratory, nutritional services, ambulatory care services, day surgery, CT scanning, physician referral service and mammography screening program.

In our most recent efforts to increase the range and quality of care to the citizens of Ennis, we have recently introduced Baylor HomeCare, a home health agency, and a 24-hour emergency room service staffed by a full-time physician trained in emergency medicine.

The medical staff of Baylor Medical Center at Ennis is involved in the review of the medical records of every patient discharged at this facility regarding medical management and overall care. HCFA's data has been carefully reviewed by the Utilization Review Committee, composed of members of the medical and hospital staffs, the Quality Assurance Committee, the Director of Medical Records and Administration.

We have evaluated the statistics HCFA has given us and, with the exception of one patient who expired after transfer to another hospital, have validated your statistics. We agree that we are within HCFA's calculations for our predicted range. In actuality, the HCFA report has rounded the 18.5% rate to 19%, so we are more securely within the range than represented.

Of the Medicare patients who made up the 18.5%, 91% were 70 years of age and older; 59% were 80 years of age and older; and almost 20% were over 90 years old. Furthermore, 2 patients of the 18.5% were 100 years old. Their longevity might be considered by some as a testimonial to the quality of care received at Baylor Medical Center at Ennis.

The Medical Staff and Administration of Baylor Medical Center at Ennis will continue to review all cases for quality and appropriateness of care rendered to the individual patient as in the past.

If you have any questions or comments, please feel free to contact me at (214) 875-9071. I sincerely appreciate the opportunity that you have afforded my hospital and others to respond to your survey.

Sincerely,

Ronald P. Hydspeth
Executive Director

RPH:hv

BAYLOR MEDICAL CENTER AT GILMER

712 North Wood
Gilmer, Texas 75644
(214) 843-5611

James A. Summersett, III
Executive Director

Medicare Provider Number: 450070

October 27, 1987

William S. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
P. O. Box 26676
Baltimore, Maryland 21201

Dr. Roper,

We appreciate the opportunity to respond to the statistics that the Health Care Financing Administration (HCFA) has compiled from Medicare Billing records. Our Medicare patients are important to us and we welcome the opportunity to discuss their care.

Baylor Medical Center at Gilmer is a modern, acute care, full service, not-for-profit hospital and a community resource. We take great pride in providing the quality of care the community expects from Baylor Medical Center. We feel as though the members of our community support their hospital and are confident in the quality of care delivered. More Gilmer residents turn with confidence to the Baylor Health Care System to fulfill their medical and physical needs than they do to any other one hospital in the area.

Baylor's commitment to quality is tangible. In 1981 the Baylor Health Care System invested approximately $6.0 million to build a new community hospital. Additionally, we have worked with the Board of Trustees, all of whom are Gilmer residents, the medical staff, the nursing staff, and administrative personnel to continue to improve the quality of care. To that end Baylor Medical Center at Gilmer now has a fully equipped Emergency Care Center, surgical suites, CT scan capabilities, intensive and critical care units, and an advanced cardiovascular laboratory. Many new services have been introduced. Baylor Medical Center at Gilmer provides physical and respiratory therapy, cardiopulmonary services, clinical laboratory, nutritional services, ambulatory care services, day surgery, thoracic and vascular surgery, urology, anesthesia, ophthalmology, orthopedics, pediatrics, physician referral service, and a mammography screening program.

In our most recent efforts to increase the range and quality of care to the citizens of Gilmer, we have introduced Baylor HomeCare, a home health agency; and 55Plus, a program designed to meet the needs of those over 55 years of age. One of the major features of the 55Plus program provides free transportation to the membership. This enhances access to the quality of care offered by Baylor Medical Center at Gilmer.

We are also extemely proud of our 109 bed skilled and intermediate care facility which is attached to our general care hospital. Unlike many other nursing care facilities nationwide, our facility has received the valued Superior rating from the Texas Department of Health, the regulatory agency for the state of Texas, for the past three years.

The medical staff of Baylor Medical Center at Gilmer is involved in the review of medical records of every patient discharged at this facility regarding medical management and overall care. HCFA's data has been carefully reviewed by the Utilization Review Committee, composed of members of the medical and hospital staff, the Quality Assurance Committee, the Director of Medical Records and Administration.

We have evalutated and validated the statistics HCFA has given us. With the exception of one case, we agree that we are within HCFA's calculations for our predicted range.

Of the Medicare patients who made up the 16% mortality rate, 85% were 70 years of age and older; 44% were 80 years of age and older; and 6% were 90 years old. There were only 7 medicare patients under the age of 70 that contributed to the 16% rate. We care for and serve a 71% Medicare population.

The Medical Staff and Administration of Baylor Medical Center at Gilmer will continue to review all cases for quality and appropriateness of care rendered to the individual patient as in the past.

If you have any questions or comments, please feel free to contact me at (214) 843-5611. I sincerely appreciate the opportunity that you have afforded my hospital and others to respond to your survey.

James A. Summersett, III
Executive Director

JAS:sn

BAYLOR MEDICAL CENTER AT GRAPEVINE

1650 West College Street
Grapevine, Texas 76051
Metro 481-1588
(817) 488-7546

Arthur L. Hohenberger
Executive Director

October 27, 1987

William S. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
P. O. Box 26676
Baltimore, Maryland 21201

Dr. Roper:

We appreciate the opportunity to respond to the statistics that the Health Care Financing Administration (HCFA) has compiled from Medicare billing records. Our Medicare patients are important to us, and we welcome the opportunity to discuss their care.

Baylor Medical Center at Grapevine is a modern, acute care, full service, not-for-profit hospital and a community resource. We take great pride in providing the quality of care the community expects from a Baylor Medical Center. We feel as though the members of our community support their hospital and are confident of the quality of care delivered. More Grapevine residents turn with confidence to the Baylor Health Care System to fulfill their medical and physical needs than they do to any other one hospital in the area.

Baylor's commitment to quality is tangible. In 1987, the Baylor Health Care System invested approximately $13.0 million to build a new patient tower and improve the existing facilities. Additionally, we have worked with the Board of Trustees, all of whom are Grapevine residents and those of the surrounding communities which we serve, the medical staff, the nursing staff, and administrative personnel to continue to improve the quality of care.

To that end, Baylor Medical Center at Grapevine now has a fully equipped Emergency Care Center, surgical suites, CT scan capabilities, intensive and critical care units, and an advanced cardiovascular laboratory. Many new services have been introduced. Baylor Medical Center at Grapevine now provides

physical and respiratory therapy, cardiopulmonary services, clinical laboratory, nutritional services, ambulatory care services, day surgery, urology, anesthesia, opthalmology, orthopedics, pediatrics, physician referral service, and mammography screening program. None of this happens without the support of the medical staff and the confidence of the community.

In our continuing efforts to increase the range and quality of care to the citizens of Grapevine and surrounding communities, we have recently introduced Baylor HomeCare, a home health agency, and 55Plus, a program designed to meet the needs of those over 55 years of age. The most recent additions to the services offered, are multiple birthing rooms and laser surgery.

The medical staff of Baylor Medical Center at Grapevine is involved in the review of the medical records of every patient discharged at this facility regarding medical management and overall care. HCFA's data has been carefully reviewed by the Utilization Review Committee, composed of members of the medical and hospital staffs, the Quality Assurance Committee, the Director of Medical Records and Administration.

Baylor has evaluated the statistics HCFA has generated. The overall calculation is under appeal. It is agreed that we are well within HCFA's calculations for each individual predicted range. Since the report shows us well within each individual range, it stands to reason that we should stand well within the total range.

It is our sincere desire that the total, which is under appeal, be recalculated and made accurate before the error is misinterpreted by the public. It is worthwhile to note that 87% of the Medicare patients included in HCFA's data were 70 years of age and older; 38% were 80 years of age and older; and 13% were over 90 years old. There were only 7 Medicare patients under the age of 70, reflected in HCFA's data.

The Medical Staff and Administration of Baylor Medical Center at Grapevine will continue to review all cases for quality and appropriateness of care rendered to the individual patient as in the past.

If you have any questions or comments, please feel free to contact me at (817) 481-1588. I sincerely appreciate the

opportunity that you have afforded by hospital and other to respond to your survey.

Kindest regards,

Arthur L. Hohenberger
Executive Director

pw
By Federal Express

BAYLOR MEDICAL CENTER AT WAXAHACHIE

1405 West Jefferson
Waxahachie, Texas 75165
(214) 937-5910

James M. Person
Executive Director

October 27, 1987

William S. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
P. O. Box 26676
Baltimore, Maryland 21201

Dr. Roper,

We appreciate the opportunity to respond to the statistics that the Health Care Financing Administration (HCFA) has compiled from Medicare billing record. Our Medicare patients are important to us, and we welcome the opportunity to discuss their care.

Baylor Medical Center at Waxahachie is an acute care, full service, not-for-profit hospital and a community resource. We take great pride in providing the quality of care the community expects from a Baylor Medical Center. We feel as though the members of our community support their hospital and are confident of the quality of care delivered. Almost seven of every ten Waxahachie residents turn with confidence to the Baylor Health Care System to fulfill their medical and physical needs.

Baylor's commitment to quality is tangible. Baylor Medical Center at Waxahachie recently completed and dedicated a $7.4 million expansion project in July, 1986. Additionally, we have worked with the Board of Trustees, all of whom are Waxahachie residents or residents of the surrounding communities which we serve, the medical staff, the nursing staff and administrative personnel to continue to improve the quality of care. To that end, Baylor Medical Center at Waxahachie now offers surgery, labor/delivery, radiology, pharmacy, physical and respiratory therapy, intensive and critical care units, cardiopulmonary services, clinical laboratory, nutritional services, ambulatory care services, day surgery, CT scanning, physician referral service and mammography screening program.

In our most recent efforts to increase the range and quality of care to the citizens of Waxahachie, we have recently introduced Baylor HomeCare, a home health agency, and a 24 hour emergency room service staffed by a full-time physician trained in emergency medicine.

The medical staff of Baylor Medical Center at Waxahachie is involved in the review of the medical records of every patient discharged at this facility regarding medical management and overall care. HCFA's data has been carefully reviewed by the Utilization Review Committee, composed of members of the medical and hospital staffs, the Quality Assurance Committee, the Director of Medical Records and Administration.

We have evaluated the statistics HCFA has given Baylor and, with the exception of two transferred patients, have validated HCFA's statistics. On the surface it appears as though we are slightly out of the predicted range in two of the diagnostic categories.

The two extremely high risk categories referred to in the HCFA report are cerebrovascular accidents, commonly referred to as strokes, and severe acute heart disease, commonly known as heart attack. The average age of the parson who fell into this stoke category in the HCFA survey was 85 years old.

The only other category which appears to be out of the predicted range is related to heart attacks. Of the Medicare patients who made up the 19% mortality rate, nearly 90% were 70 years of age and older; 60% were 80 years of age and older; and more than 18% were over 90 years old.

It is worthwhile to note that 25% were admissions from nursing homes which rely on Baylor Medical Center at Waxahachie for their emergencies and critically ill residents. There were only 3 Medicare patients under the age of 60 that contributed to the 19%. Furthermore, 20 patients of the 19% were between 90 and 100 years old.

Baylor Medical Center at Waxahachie has been an advocate of annual physicals and other preventative health activities to combat heart disease. Baylor continues to participate in American Heart Association activities and distribute material concerning this disease to members of our community. Baylor believes that education is a quality of care issue.

The Medical Staff and Administration of Baylor Medical Center at Waxahachie will continue to review all cases for quality and appropriateness of care rendered to the individual patient as in the past.

If you have any questions or comments, please feel free to contact me at (214) 937-5910. I sincerely appreciate the opportunity that you have afforded my hospital and others to respond to your survey.

Sincerely,

James M Person

James M. Person
Executive Director

Medicare Provider Number: 450-372

BAYLOR UNIVERSITY MEDICAL CENTER

3500 Gaston Avenue
Dallas, Texas 75246
(214) 820-0111
Cable Address: BAYLORDAL

October 28, 1987

William S. Roper, M.D., Administrator
Health Care Financing Administration
Health Standard and Quality Bureau
6300 Security Boulevard, Room 2D2
Meadows East Building
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to examine and respond to the mortality information collected on certain Medicare patients who were hospitalized at Baylor in 1986. Medicare patients comprise a large and important segment of Baylor's patient population, and we welcome the opportunity to discuss their care.

In view of the types of patients Baylor treats, I am comfortable with where Baylor University Medical Center falls in the predicted ranges. However, we have used this study as an opportunity to carefully review all data on Medicare patients for the time period in question, and have some additional data for your review.

Baylor is a nationally known tertiary care center to which the most acutely ill patients are referred for care. In fact, 52 percent of our patients come from outside Dallas.

Baylor University Medical Center is, in terms of admissions, Texas' largest private hospital and the second-largest church related hospital in the country. We are licensed for 1,455 beds, and experienced nearly 40,000 patient admissions last year.

Baylor is a teaching hospital, with residency programs in every specialty of medicine. Our medical staff numbers close to 1,000 physicians. We are also a center for medical research, now investigating possible medical uses for lasers for the Department of Defense.

We have well known centers for the treatment of cancer, heart and digestive diseases, as well as 18 other centers for the treatment of a variety of health problems ranging from asthma to the transplantation of hearts, livers, kidneys and bone marrow. In fact, Baylor is a designated Center of Excellence by the National Institute of Health for liver transplantation.

Our emergency department is equipped with two helipads, permitting Baylor to receive the most acutely ill patients from throughout the region.

In examining your findings, we involved a number of people from our hospital, including top management, our medical staff leadership, the physician chairman of our utilization review and quality assurance programs and our key medical records personnel. We undertook an exhaustive review of the data, and uncovered a great deal of significant information.

When we looked at the number of Medicare cases in the sixteen categories the Health Care Financing Administration examined, we found that we actually had 870 more patients, and 39 more deaths, than were used for this report. These additional cases lowered our mortality rate from 11 percent to 10 percent.

This also significantly lowered mortality rates in all 16 categories sometimes by as much as eight percentage points.

We then looked at the two categories--cerebrovascular accidents and low-risk heart disease--where we fell at the high end, or slightly above the predicted range. To ensure the most thorough examination, we looked into the medical records of every reported death in these two categories.

It should be noted that we actually had 281 patients in the cerebrovascular category. Again, using your formula, we calculated a mortality rate of 26 percent--eight percentage points lower than your calculation. Of the 73 deaths, 58 percent had one or more additional significant health problems the Health Care Financing Administration classifies as "serious." Nearly 70 percent of patients who died were 75 years of age or older.

We then examined the category of low-risk heart diseases. We identified 302 more patients, and four more deaths. Thus our mortality rate is actually six percent (versus the calculated rate of eight percent). Of the 64 deaths, nearly one third of the patients had undergone either a coronary artery bypass graft procedure; a heart valve replacement or aneurysm surgery, usually considered high-risk procedures. Seventy four percent of these patients had, at time of death, one or more serious medical conditions besides heart disease and 42 percent were 75 years of age or older.

In looking at all other categories, Baylor fell at the low to mid-point of the range except for cancer, gastrointestinal catastrophic illness, severe chronic heart disease, severe acute heart disease and sepsis, where our rates not only were below the calculated rate but also beneath the range. For example, in cancer we show a mortality rate of 16 percent (the predicted range was 18 percent to 31 percent); for severe acute heart disease our mortality rate was 26 percent (the predicted range was 31 percent to 46 percent).

Using the Health Care Financing Administration formula as published, here are Baylor's mortality percentages:

Cancer	16%	Sepsis	22%
Cerebrovascular accidents	26%	Severe trauma	6%
Severe acute heart disease	26%	Ophthalmologic dis.	0%
Gastrointestinal catastrophes	7%	Gynecologic dis.	5%
Metabolic and electrolyte disorders	15%	Low risk heart dis.	6%
Pulmonary disease	15%	Gastrointestinal dis.	0%
Renal disease	17%	Urologic disease	2%
Orthopedic conditions	.05%		

We also discovered from this review that the average age of the Medicare patients who died, and who were reviewed in this study, was 76 years. Also, 55 percent of all patients who died outside Baylor did so after transfer to either a hospice hospital (for terminally ill patients), a skilled nursing facility, a nursing home or to the care of a home health medical professional.

Baylor has an active Quality Assurance program, and addresses any quality issues identified with the medical staff.

We appreciate the opportunity to have reviewed the Health Care Financing Administration's data, and the opportunity you have given us to respond.

Sincerely,

Boone Powell Jr.
President

An Affiliate Of
Humana

3080 College Street
P.O. Box 5817
Beaumont, Texas
77706-0817
Telephone 409/833-1411

October 26, 1987

Beaumont Medical Surgical Hospital

William L. Roper, M.D.
Administrator, H.C.F.A.
Department of Health & Human Services
Attn: HSQ-148-GNC
P. O. Box 26676
Baltimore, Maryland 21201

Re: Response to HCFA on Hospital Mortality Rates
Provider #450666
Beaumont Medical Surgical Hospital

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Beaumont Medical Surgical Hospital supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

**Beaumont
Medical Surgical
Hospital**

In our review of the data you sent us you claim many deaths occurred outside the hospital; we are unable to validate this data. Generally, with reference to hospital deaths we have found your data to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Gary R. Grover
Executive Director

cc: Pat Davis
Patrick Stone

BELLVILLE GENERAL HOSPITAL

409/865-3141 • P.O. Box 148 • 44 N. Cummings • Bellville, Texas 77418

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Attn: William L. Roper, M.D.
Administrator

RE: Hospital ID #45-0253

Dear Dr. Roper:

The review of all deaths at Bellville General Hosptial are evaluated monthly by our Medical Staff. The chart is discussed by the physicians to determine that quality care was appropriate for the diagnosed illenss. Bellville has two (2) nursing homes with 243 beds total within two miles of the hospital. Two other nursing homes with 200 beds are within 17 miles of the hospital. Approximately 42.5% of our census is Medicare. The average age of the 1986 deaths attributed to Bellville General was 78.3 years. All deaths were under the range of predicted mortality rates.

Sincerely,

Charles W. Guidry
Administrator

CWG/jsr

BELTWAY COMMUNITY HOSPITAL

"Personal Care - Closer to Home"

Health Care Financing Administration
Room 2-D - 2 Meadows East Blvd.
6300 Security Blvd.
Baltimore, Maryland 21207

Dear William L. Roper, M.D.

Thank you for this opportunity to respond to the release of data on hospital mortality rates for the year 1986.

Beltway Community Hospital is a ninety nine (99) bed acute care facility, whose case mix includes patients with medical and surgical illness. We offer medical services in Emergency Department, Obstetrics, Special Care Unit as well as general medicine and surgery.

Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring system. The Medical Staff conducts an intensive review of the medical record of every patient, who expires, at this facility, regarding case management. The Joint Commission on Accreditation of Hospitals recently awarded our hospital accreditation for three (3) years.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: The hospital Administrator, Chief of Staff, Physician Chairman of the Utilization Review Committee, Director of Utilization Review and Quality Assurance, and the Director of Medical Records. Our actual mortality rate is within the range of predicted mortality rates, but we would like to address one catagory, HS - Severe Acute Heart Disease. We had ten (10) cases (six (6) expired) leaving us with a mortality rate of 60%. Four (4) of the six (6) expired cases arrived in our Emergency Department in a full Code for Cardiopulmonary Arrest. The patients length of stay varied from 2 @ 3 hours, 1 @ 23½ hours and 1 @ 38 hours. All of these cases expired despite aggressive treatment. Without these cases our mortality rate would have been 20%.

Thank you for the opportunity to present this response.

Sincerely,

Anthony Degina

Anthony Degina
Hospital Administrator

AD/jm

4040 Red Bluff Road, Pasadena, Texas 77503 / (713) 473-3311
A Member of the Charter Medical Corporation family of quality health care facilities

BCHD
BEXAR COUNTY HOSPITAL DISTRICT 4502 MEDICAL DRIVE, SAN ANTONIO, TEXAS 78284 (512) 694-3030

October 27, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the Health Care Financing Administration (HCFA) data on Medical Center Hospital's (MCH) mortality rates for the period January 1 through December 31, 1986.

Upon receipt of this information, we convened a review team to study the mortality statistics and examine specific medical records from selected diagnostic categories. The team was composed of the Associate Executive Director of Medical Services, the Physician Advisor for Utilization Review, hospital administrators, representatives from Medical Records, and Utilization Review staff. After thorough review of the statistics and individual records, it was the opinion of the review team that all patients received appropriate care while treated in this hospital. The team did however, discover issues unrelated to quality of care that directly and inappropriately affect our mortality rates. These issues are explained in detail below.

A study of cases involving patients who died outside our hospital revealed five patient deaths that should not be included in the mortality cases assigned to MCH. These five cases appear in Table 1 along with the patient identifiers your agency provided.

Table 1

PATIENT ID NUMBER (HIC)	SURNAME (FIRST 6 LETTERS)	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH
[redacted]		07/01/86	07/16/86	07/24/86
		11/11/86	11/12/86	11/26/86
		08/11/86	08/17/86	08/25/86
		09/06/86	09/12/86	10/06/86
		02/14/86	02/18/86	02/23/86

The first four patients listed were transferred from our hospital to the Audie L. Murphy Memorial Hospital, a Veteran's Administration (VA) hospital located in this community. According to death certificates on file at the San Antonio Metropolitan Health District and records in the Bexar County Medical Examiner's office, all four patients died at this VA hospital. Because the reimbursement mechanism for care provided in a VA hospital is completely independent from the Medicare program, your agency appears to have no record of the last admission to the VA hospital for these four patients. Thus, due to the disparate accounting systems between the Health Care Financing Administration and the Veteran's Administration, MCH was incorrectly identified as the last hospital of treatment.

The fifth case listed in Table 1 represents a patient whose official cause of death was "asphyxia by hanging" according to Medical Examiner's records. A suicide which occurs outside the hospital is beyond a hospital's control and therefore, in this case, should not be included in MCH's data.

Our study also revealed 21 records with erroneous data that need correcting prior to publication in December. The data errors identified include dates of admission, dates of death, principal diagnoses and comorbid conditions. In the opinion of the reviewers, correcting the errors will affect significantly the final computation of mortality rates and ranges for MCH. Rather than identify each error and the corresponding correction required, we have provided you a list of cases with complete and corrected information (see Table 2). Records for which the corrected diagnoses change the diagnostic categories assigned by your agency are denoted by an asterisk. This occurred in seven cases. After your agency eliminates the five records listed in Table 1 and corrects the data for the 21 records appearing in Table 2, the mortality rates and predicted ranges re-computed for Medical Center Hospital will be based upon complete and accurate information.

This hospital shares the opinion of many other health care organizations that mortality statistics do not measure the quality of care at any individual hospital. For this reason, our hospital will continue, through our internal Quality Assurance Committee, to provide on-going review of patient care activities and ensure that quality of care standards are being met.

Sincerely,

John Guest
Executive Director
(Medicare Provider #450213)

Table 2

Medical Records with Corrected Dates of Admission,
Dates of Death, Diagnoses, and Comorbid Conditions

PATIENT ID NUMBER (HIC)	SURNAME (FIRST 6 LETTERS)	DIAGNOSTIC CATEGORY	DATE OF ADMISSION	DATE OF DISCHARGE	DATE OF DEATH	PRINCIPAL DIAGNOSIS	COMORBIDITIES FIRST	SECOND	THIRD	FOURTH
[redacted]		CE	09/22/86	09/25/86	09/25/86	436	162.9	286.6	427.5	431
[redacted]		UN‡	12/22/85	12/22/86	12/22/86	038.9	203.0	585	276.2	288.0
[redacted]		SE‡	11/28/86	12/14/86	12/14/86	038.1	421.0	434.1	427.31	496
[redacted]		HL	07/01/86	07/16/86	07/24/86	416.9	707.1	250.70	278	607.83
[redacted]		HL	02/28/86	02/28/86	02/28/86	414.0	427.5	250.00	348.1	
[redacted]		TR	08/23/86	09/12/86	09/12/86	820.09	402.91	599.0	041.7	427.5
[redacted]		TR	08/10/86	08/30/86	08/31/86	820.8	038.1	112.9	427.5	707.0
[redacted]		PN‡	09/18/86	09/25/86	09/25/86	415.1	453.8	396.3	780.3	427.5
[redacted]		UN	12/17/85	01/05/86	01/05/86	335.24	790.7	410.9	707.0	427.5
[redacted]		RN‡	11/04/86	11/17/86	11/17/86	586	V64.1	185	198.5	427.5
[redacted]		UN	11/13/86	11/14/86	11/25/86	780.6	403.9	V42.7	585	
[redacted]		UN	06/28/86	07/13/86	07/13/86	996.6	590.80	041.4	707.0	438
[redacted]		UN	05/03/86	05/07/86	05/07/86	011.1	410.0	578.0	427.5	518.5
[redacted]		CA‡	01/29/86	02/13/86	02/13/86	157.0	427.1	511.9	458.9	286.6
[redacted]		CE‡	04/22/86	05/10/86	05/10/86	434.9	433	780.0	507.0	041.1
[redacted]		UN	05/02/86	05/06/86	05/06/86	345.3	571.2	572.2	271.3	789.2
[redacted]		UN	09/11/86	10/06/86	10/06/86	780.3	799.0	496	427.9	599.0
[redacted]		SE‡	11/17/86	11/20/86	11/20/86	038.40	496	427.31	482.1	558.9
[redacted]		UN	02/06/86	03/05/86	03/05/86	707.0	998.5	574.10	427.5	906.8
[redacted]		UN	02/16/86	02/21/86	02/21/86	785.59	998.1	790.7	572.3	427.5
[redacted]		UN	05/21/86	06/16/86	06/16/86	807.29	901.1	810.00	812.01	860.4

‡ Represents a change in diagnostic category from that assigned by HCFA.

AMI Brownsville Medical Center

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The following information is to be attached to the HCFA mortality information on Medicare patients who were treated in Brownsville Medical Center (BMC) (Provider no. 450028) in 1986 and who died within 30 days of their last admission of 1986.

Brownsville Medical Center is a 168-bed acute care facility whose case mix index, which indicates the severity of illness, includes many patients with major medical and surgical illnesses. This case mix index requires a large number of resources in treatment and reflects a high number of patients with severe illnesses.

In order to serve the medical needs of such patients, BMC offers a wide spectrum of services including oncology, acute renal dialysis, a 12-bed intensive care/coronary care unit, pulmonary rehabilitation, 24-hour emergency care as well as general medicine and surgery.

The medical staff of BMC conducts a review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an ongoing process and is a very important part of BMC's quality assurance program.

The hospital's specific mortality data reported by HCFA has been carefully reviewed by the Medical Records Director, Quality Assurance Coordinator, Utilization Review Coordinator and members of the medical staff. Our overall percentage of deaths falls within HCFA's predicted range.

While BMC recognizes the importance of the mortality data we understand that HCFA does not use the information to make judgements about the quality of care in an individual hospital or to make comparisons among hospitals. The data, we believe, is more reflective of the conditions and types of patients who are admitted to

P.O. Box 3592 1040 West Jefferson Brownsville Texas 78520 512 544-1431

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

the hospital.

For instance, 27% (41 patients) of the reported deaths of the HFCA summary for BMC were admitted from nursing homes and 68% (104 patients) were admitted through our emergency room. Patients who are admitted from nursing homes or through the emergency room may be more chronically ill or have more guarded prognoses. As noted, several of these patients fell into this description.

The families of thirty-five percent (54 patients) of the patients who expired requested a "no code" (no lifesaving measures to be taken). Such circumstances would indicate the patient was at the end of a long terminal illness. More specifically, 50% of the patients whose deaths fell in the category of cerebrovascular accidents were "no codes" and 76% of the patients whose deaths fell in the category of cancer were "no codes".

The average age of the deaths listed in the HCFA mortalility report was 75. It should also be noted that the average age of those expired Medicare patients whose principal diagnoses was cerebrovascular accidents was 78. Older age patients such as these may have less resiliance to illness than younger patients.

Our review of the data also showed that only six (9%) Medicare patients with urologic disease expired. Of the six patients who expired, four had pre-existing cardiac conditions and later experienced myocardial infarctions.

All of the expired Medicare patients whose principal diagnoses was renal disease were admitted with chronic renal failure and their average age was 79. There were only four patients whose mortalities fell into this category.

It should be noted that renal disease patients may frequently develop a multitude of complications. BMC is the only hospital in Brownsville that offers acute renal dialysis and that provides care for such patients.

We are pleased that BMC falls within HCFA's predicted mortality range. However, our in-depth analysis indicates that our actual mortality experience is lower than that reported by HCFA. Two patients who are listed in the BMC hospital-specific mortality data expired at institutions other than BMC and their causes of death were not related to the disease conditions treated at BMC. Eleven cases with incorrect dates of death were also identified in the analysis. Please

see the attached list of corrected dates.

While the review of this data was an in-depth analysis by our medical staff and quality assurance personnel, the review of all mortalities, as stated previously, is an ongoing process at BMC; it is not limited to only those occasions when statistics such as mortality data are released.

Sincerely,

G. Tucker Grau
Executive Director

GTG/jr

BURLESON COUNTY HOSPITAL DISTRICT
Burleson County Hospital
1101 WOODSON DRIVE
CALDWELL, TEXAS 77836

October 22, 1987

TO WHOM IT MAY CONCERN:

The average age of the Medicare patients of Burleson County Hospital expiring in 1986 as listed on this report was 81.6 years of age. Not all of these patients actually expired at Burleson County Hospital but expired sometime after discharge in another health care facility. The actual Mortality Rate of Burleson County Hospital shown stayed well within the expected mortality rates predicted.

Beverly Mahlmann
Administrator

BDM/aw

"the best care comes from caring"

CAMPBELL MEMORIAL HOSPITAL

713 EAST ANDERSON
WEATHERFORD, TEXAS 76086
(817) 594-8751

October 20, 1987

Dr. William Roper
HCFA
Health Standards & Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to reply to the release of data on the 1986 mortality rates. Parker County Hospital District dba Campbell Memorial Hospital is a 97 bed acute care facility functioning as a Hospital District. It is fully accredited by the Joint Commission on Accreditation of Hospitals.

On a continuous basis, a committee of physicians and other disciplines within the hospital reviews each death for appropriateness of care. The statistical data has been reviewed and is accurate, with minor exceptions. Using this type of data is not a totally accurate way to assess the quality of care at a medical facility, although it is a way the community can look at a hospital's care. The overall low mortality rate in our particular facility is indicative of concerned medical care geared to the needs of the large geriatric population we serve.

It should be noted the average age of deaths within the study at Campbell Hospital is 80.5 years. Many of the patients had multiple health problems. 30% of these patients were in our hospital for 24 hours or less and at the time of admission were in the end stages of their illnesses. Some of the deaths attributed to our facility were actually post discharge from the hospital and were unrelated to their illnesses. None the less, for the purpose of this study, the deaths were counted in our statistics simply because ours was the last medical facility in which they were treated.

The 0% death rate for major trauma is a direct tribute to the capabilities of the emergency team and physicians in handling trauma. Knowing what types of trauma should be stabalized and moved rapidly to a tertiary care center, and which types can be appropriately and safely managed in a community hospital setting are all key factors.

Respectfully,

Charles Meisner

Charles Meisner
Administrator

CM:dr

CHARLTON METHODIST HOSPITAL

Post Office Box 225357 Dallas, Texas 75222-5357

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Please include the following comments in your publication of mortality data - for Medicare patients treated during 1986.

Charlton Methodist Hospital (Charlton) is a 147 bed community teaching hospital located in Southwest Dallas. Charlton is a member of the Methodist Hospitals of Dallas system which operates two other hospitals in Dallas, Methodist Medical Center and Southeastern Methodist Hospital. Charlton has over 115 physicians on its active staff. As a result of Charlton's affiliation with Methodist Medical Center, an additional 280 highly trained physicians representing all major specialties and subspecialties provide consultation to our patients. This affiliation, coupled with Charlton's excellent medical staff, has enabled the hospital to care for patients with illnesses that might otherwise require hospitalization at a larger specialty medical center. This uniqueness has also allowed Charlton to become a major provider of health care for patients in Southwest Dallas County.

Quality of care is the utmost concern of Charlton Methodist Hospital's medical staff, management, and governing board. Members of Charlton's medical staff formally review every mortality in our facility for appropriateness of care as part of an ongoing systematic process to assure that our patients receive the highest quality of care.

Charlton's quality assurance program encompasses reviews of all deaths, drug usage, and quality screens which focus on timeliness of medical treatment and services, appropriateness of treatment, and quality of treatment and care. The use of blood and blood products, the administration of antibiotics and indications for surgery are also routinely reviewed by medical staff members.

Several points should be noted before commenting directly on the data being released by the Health Care Financing Administration (HCFA). First, the ability of the model to detect differences in the quality of care has not

been evaluated. Second, the HCFA data assumes that each hospital's patients are average except with respect to a few characteristics included in the study. Each patient is unique, however, and the quality of care must, as a result, be examined in detail on a case by case basis. Only through this type of approach can meaningful quality review be accomplished. Third, the model does not include measures of how ill a patient was at the time of admission, whether the patient was transferred to the hospital from a nursing home, or whether the patient had a terminal illness. Fourth, the model was based on the particular illness which caused the admission. Many times, the cause of death is related to an illness other than the one creating the need for the hospital admission. An example might be that of a patient included in the pulmonary category whose death was caused by terminal cancer. Finally, the data submitted is not all-inclusive. The HCFA statistical model included only a portion of the Medicare patients treated during the year. The report submitted by HCFA included only 920 cases. Our records indicate 1,367 Medicare admissions during the same time period.

The hospital specific mortality data released by HCFA has been reviewed by the President of the Medical Staff, Physician Chairman of Utilization Review, Surgery Department Chairman, Family Practice Department Chairman, Internal Medicine Department Chairman, and members of hospital administration and the findings are summarized as follows.

Charlton has an excellent discharge planning service, coordinated by our social service department, which has been very successful in securing hospice or skilled nursing care when deemed appropriate by the patient, family, and the patient's physician. Hospice services are provided for the terminally ill patients who are no longer in need of acute hospital care. Twenty-five, or 75%, of the patients which expired after discharge had been transferred to a hospice, nursing home, extended care facility, or another hospital. The most common diagnoses of these patients were cancer (14 patients) and heart disease (11 patients).

It is important to also consider the ages of these patients, the source of their admission and their general state of health upon admission. The average age of the patients in the HCFA study was 77. Thirty-six percent of the patients were admitted to the hospital from either a nursing home, extended care facility, or another hospital. Thirty-five percent of the patients in the study expired within 48 hours of admission because of the severity of their illness upon admission. Eighty-eight of the charts reviewed reflected that the patients, families, and physicians agreed that no heroic measures or long term life support should be undertaken in the event of a cardiac or pulmonary failure.

The subset of pulmonary disease patients included in the study had a mortality rate of 31% and a predicted mortality rate of 10% to 27%. The following information should be noted in regard to this category: the average age of this group of patients was 78; twenty-one of the patients

and/or their families, after careful consideration and consultation with their physicians, had requested that no heroic measures or long term life support be undertaken in the event of pulmonary or cardiac failure; thirteen of the patients were admitted from a nursing home or extended care facility; five of the patients in this category expired from cancer or heart disease rather than pulmonary disease; and the majority of these patients had other illnesses contributing to the severity of their illness (thirteen patients had one additional illness, seven patients had two additional illnesses, five patients had three additional illnesses, and one patient had four additional illnesses). It should also be noted that fourteen, or 47%, of the patients expired within 48 hours of admission. The patient's physician noted in the chart that death was anticipated in twelve of these patients as a result of the advanced state of their illness and other complications upon admission. Both of the remaining two patients expired as a result of cardiac failure despite aggressive treatment. One of these two patients had been in another hospital twice during the last two weeks prior to admission. In addition to pulmonary disease, this patient was suffering from kidney disease, heart-disease, diabetes and high blood pressure.

The subset of sepsis (blood poisoning) patients included in the study represented a very small number of patients. The wide range of the predicted mortality rates from 12% to 64% is an indication of the difficulty in predicting death rates in this category, especially when there are only a few patients included in the study. Of the seven patients who expired from sepsis, three expired within 24 hours of admission, which is an indication of the severity of illness of these patients upon admission. Two of these three deaths were anticipated as a result of the advanced state of their illness upon admission. The remaining patient was admitted from a nursing home with sepsis, respiratory distress and cancer and expired despite aggressive treatment. Five of the seven sepsis patients and/or their families had requested, after consultation with their physician, that no heroic measures or long term life support be undertaken in case of pulmonary or cardiac failure. These patients also had a number of other complicating illnesses (one patient had one additional illness, three patients had two additional illness, two patients had three additional illnesses, and one patient had four additional illness).

The medical staff at Charlton Methodist Hospital has always been concerned about the quality of care delivered to our patients. Because of this long-standing concern for quality, the medical staff will continue its efforts to review the care of all patients for both appropriateness and quality of care.

Sincerely,

Kim N. Hollon
Executive Director

KNH:jm

Charter Community
Hospital of Cleveland

P.O. Box 1688
300 E. Crockett
Cleveland, Texas 77327
(713) 593-1811

October 22, 1987

William L. Roper, M.D.
Administrator
Dept. of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Charter Community Hospital is a 115 bed acute care facility with a six (6) bed Special Care Unit located in Cleveland, Texas. We provide many services to the community which include Orthopedics, Pediatrics, Gastroenterology and a 24 Hour Level 2 Emergency Room as well as General Medicine and Surgery. We are fully accredited by the Joint Commission on Accreditation of Hospitals and Peer Review activities are performed by Texas Medical Foundation, which insures that quality and appropriate care is provided to all of our patients.

Quality Assurance activities are performed hospital wide and mortalities are reviewed regularly to monitor appropriateness of care and services rendered. The mortality data provided by HFCA was reviewed by the Administrator, Chief of the Medical Staff, Director of Quality Assurance, the Utilization Review Coordinator and the Director of Medical Records. All data was verified to be accurate, with a few discrepancies that will be explained by diagnosis. Our findings were as follows:

Cancer: Predicted range 13-53 % 11 patients represented
Actual range 55 %

1. All cases were diagnosed as having cancer with a metatasis and/or other organ failure at the time of admission to the hospital.
2. Four (4) cases were placed on a DNR (no code) by the families of the patient.

3. The one death reported by HCFA as occuring after discharge,

A member of The Charter Medical Corporation family of quality health care facilities.

actually occurred in the hospital on the second day of admission.

Severe Chronic Heart Disease: Predicted range 9-39 % 1 patient represented
Actual range 4 %

1. The one case reported was reviewed and found to be incorrect in that the patient had a myocardial infarction and should have been in the diagnosis group of Severe Heart Disease.

2. Medical staff review concurred that we have a higher volume of Severe Acute Heart Disease and that most cases of Severe Chronic Heart Disease are treated as outpatients.

Trauma: Predicted range 2-37 % 1 patient represented
Actual range 6 %

1. In this case the patient died of cardiac complications 5 days post-op prosthetic hip joint replacement.

2. Family of the patient requested DNR (no code).

3. Severe traumas are transported to tertiary hospitals as soon as they are stable.

In summary, our findings indicate there is proper rationale for the diagnoses that falls outside of the predicted range. We feel that our facility renders the type of care that consumers expect.

We wish to thank you for the opportunity to respond to the data that you provided. We feel confident that we will continue to provide this type of quality care for all of our patients.

Sincerely,

Timothy W. McGill
Administrator

/bc

CHARTER
SUBURBAN·HOSPITAL

October 23, 1987

William L. Roper
Administrator
Health Care Financing Administration
Hubert H. Humphrey Building, Room 314G
200 Independence Ave. S.W.
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of the 1986 data on hospital mortality rates. The Director of Medical Records has validated that the data is accurate.

The following summarizes our findings by diagnostic categories:

HCFA Mortality
1986

Cancer 28 cases - 13 deaths (34%)

6 "no code*" (including 1 discharge)
1 " do not intubate"

5 expired after discharge
1 - 1 day
1 - 6 days
1 - 13 days
1 - 15 days
1 - 19 days

1 under 24 hours

*no code - The family and/or patient has requested that no heroic measures be taken. (i.e., C.P.R., etc.)

Cerebrovascular accidents - 19 cases 7 deaths (37%)

5 "no-code"/no heroic measures requested
1 expired after discharge 1-13 days

Severe acute heart disease - 27 cases 14 deaths (52%)

3 "no code"
3 under 24 hours
1 under 48 hours

1011 N. Galloway Ave. • Mesquite, Texas 75149 • (214) 320-7000

HCFA Mortality 1986 (continued)

Severe chronic heart disease - 35 cases 8 deaths (23%)

2 "no code"
2 under 24 hours
3 expired after discharge
1 - 9 days
1 - 11 days
1 - 20 days

Pulmonary disease - 95 cases 24 deaths (26%)

16 "no code" (including 1 under 24 hours)
(including 1 under 48 hours)

6 expired after discharge
1 - same day
1 - 2 days
1 - 3 days
2 - 6 days
1 - 14 days

2 under 24 hours
3 under 48 hours

It should be noted that in 67% of all pulmonary disease deaths, the family requested no heroic measures be taken to save the patient.

Again, thank you for the opportunity to present this response. If you or anyone receiving this information has additional questions, please do not hesitate to call Charter Suburban Hospital (214/320-7000).

Sincerely,

Kenneth W. Randall

KWR/tkr

CITIZENS GENERAL HOSPITAL
A Healthcare Resource of Hunt Memorial Hospital District

4215 Joe Ramsey Blvd. P.O. Drawer 1059 Greenville, Texas 75401 214 454-2120

Hospital Provider Number: 450352 October 15, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

COMMENTS ON THE HCFA MORTALITY DATA

Data Verification

1) There are 2 cases in which the patients were alive at the time of discharge but died at a skilled nursing facility on the same date. They are: [redacted] CA 092 M 9/19/86 9/23/96 9/23/86 1985
CE 071 F 11/21/86 12/11/86 12/11/86 431

According to Health Care Financing Administration (HCFA) Data:

2) A total of 172 medicare patients admitted to Citizens General Hospital died within 30 days of admission. HCFA's data also revealed a total of 1,181 medicare patients were admitted in 1986.

Our own records indicate that 1,829 medicare admissions occurred in 1986. This discrepancy reflects multiple admissions as the HCFA total excludes all but the last admission of patients admitted more than once during the year. We have no way of verifying whether the HCFA total of medicare patients admitted is correct.

Our own records indicate 172 medicare deaths, 130 died as inpatients and 42 died after discharge but within 30 days of admission. It is impossible to verify the percentage of patients dying after discharge as information concerning death after discharge is not included in the patient's medical record.

In none of the diagnostic categories did the hospital's actual mortality rates fall outside the range of HCFA's predicted mortality rates.

CITIZENS GENERAL HOSPITAL
A Healthcare Resource of Hunt Memorial Hospital District

4215 Joe Ramsey Blvd. P.O. Drawer 1059 Greenville, Texas 75401 214 454-2120

3) One factor affecting our statistics is the fact that we treat a significient number of medicare patients each year. For our fiscal year ending September 30, 1987, medicare patients accounted for 35% of our census and 40% of our total patient days.

4) HCFA reveals a 15% Actual Mortality Rate based on 172 deaths per 1,181 admissions. In actuality, after excluding the 42 deaths occurring after discharge and total medicare admissions of 1,829, our actual medicare mortality rate is 7%. The hospital's overall mortality rate for the year 1986 is 2.6% (based on 167 deaths per 6,356 total admissions).

Sincerely,

Nancy Craig

Nancy Craig,
Professional Service Director

NC/ck

Citizens
MEDICAL CENTER

October 19, 1987

William L. Roper, M. D.
Administrator - HCFA
Department of Health and Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Dear Dr. Roper:

The following information for Citizens Medical Center, Provider Number 45-0023, is to be attached to the Hospital Specific Report of Mortality Rates for calendar year 1986, prior to public disclosure.

Citizens Medical Center is a 308 bed acute care facility in South Central Texas. The hospital is the only facility within the surrounding seven county region that performs open heart surgery and cardiac catheterization. A full range of diagnostic and therapeutic oncology services is available for the detection and treatment of cancer. Neurosurgery services are also available at the facility. Additionally, Citizens has a complete emergency trauma center including a heliport available and used by the entire region.

For these reasons, the hospital is a major referral center for physicians in the surrounding counties. Forty percent of the hospital's admissions are from the surrounding counties and beyond.

The facility's mortality data as provided by HCFA has been carefully reviewed by the hospital administration and the director of the Medical Record Department. The following differences were noted:

1. The total Medicare cases for 1986 were 1,684 - not 1,443 as reported. These cases represent 2,405 admissions for 1986.
2. The correct overall mortality rate for the hospital, adjusted for the above discrepancy, is 9.4% instead of 11% as reported, and is well within the predicted mortality rate for the severity of illness of the patients seen by the hospital.

2701 Hospital Drive ■ Victoria, Texas 77901-5749 ■ (512) 573-9181

3. Ninety-four percent (94%) of the low-risk and uncategorized death cases involved significant illnesses that, had they been the chief reason for the hospitalization, would have been categorized as high-risk cases.

A significant number of the low-risk cases involved multiple admissions during the year of death, indicating a greater degree of illness. Twenty-two percent (22%) of the cases resulting in death were transfers from other acute care facilities. Thirty-nine percent (39%) of the cases involved patients arriving through the Emergency Room, several of whom had incurred traumatic accidents at home or at work.

The Medical Staff at Citizens Medical Center conducts an ongoing intensive review of every patient who expires at the facility regarding their overall care and medical management. This is an integral part of the hospital quality assurance program which assures the highest standards of care to all patients. The Joint Commission on Accreditation of Hospitals reviews the quality assurance programs and commends the facility's excellent peer review process. The Texas Medical Foundation, the Peer Review Organization for the State of Texas, also conducts monthly peer reviews which have all been very positive for the hospital.

Citizens Medical Center is dedicated to the betterment of healthcare for the community of patients that it serves, and the hospital will continue to monitor all care given in its efforts to provide the best healthcare available to all its patients.

Sincerely,

David P. Brown
Administrator

DPB/slj

RESPONSE FOR HCFA MORTALITY DATA

Thank you for the opportunity to respond to the release of the data on our hospital's mortality rate for the year of 1986.

Clay County Memorial Hospital is 50 bed rural hospital serving a 11,000 area population in North Texas and Southern Oklahoma.

Mortality review is conducted monthly by the Medical Staff. Departments that participated in the analysis of the HCFA Mortality Data include:
Administration
Medical Record
Medical Staff

There were twelve (12) categories reviewed in depth. The Medical Record Director has reviewed that with minor exceptions, the HCFA data is accurate. The following summarizes our findings by diagnostic categories.

HIGH RISK GROUPS

CANCER PATIENTS - One patient or 0.2% was in this category with an age of 72. This patient had other disease processes and there was no order to resuscitate as requested by family.

CARDIOVASCULAR ACCIDENTS - Three (3) patients or .08% were in this category with an average age of 81. 66 2/3% had other disease processes and 33 1/3% had expected outcome. 66 2/3% were received from area Nursing Homes and one was transferred from an acute bed.

SEVERE HEART DISEASE - Six (6) patients or 17% were reported in this category with an average age of 82. 50% were received from Nursing Homes and one patient or 16% died within 1 day after discharge. 66 2/3% were listed as critical or terminal on admission and 33% had other disease processes.

CHRONIC HEART DISEASE - Four (4) patients or 11% were in this category. 50% were from Nursing Home with an average age of 75. 50% had other disease processes and 25 % died outside the hospital after discharge. 50% were in guarded or critical condition on admission.

GASTROINTESTINAL CATASTROPHE- Two (2) patients or 5% were reported in this category with an average age of 71.5 years. 50% had two or more disease processes. 50% were transferred from an acute bed. 50% of this category had expected death.

PULMONARY DISEASE - Five (5) patients or 14% were reported in this category with an average age of 80 years. 40% were received from Nursing Homes and 80% had other disease processes. 40% were listed as terminal or guarded on admission and 40% of the patient's family requested no CPR be performed.

RENAL DISEASE - Three (3) patients or 8% were included in this category with an average age of 79 years. 100% had other disease processes. 33 1/3% were transferred from an acute bed and 40% were listed as terminal or near terminal on admission. 100% of families requested no CPR.

SEPSIS - One (1) patient or 0.2% were included in this category with an average age of 84 years. This patient had other disease processes and the family requested no CPR be performed.

METABOLIC AND ELECTROLYTE DISORDERS - One (1) patient or 0.2% were in this category with an age of 69. The patient was terminal on admission and considered to be a possible expected outcome of death. This patient was received from a Nursing Home.

LOW RISK GROUPS

GENITOUROLOGIC DISEASES - One (1) patient or .02% with an average age of 85. The patient had other disease processes.

LOW RISK HEART DISEASE - Two (2) patients or 5% were in this category with an average age of 92. 100% were terminal on admission and 50% of families requested no CPR be performed. 100% were expected outcome of death in this category.

ALL OTHER CONDITIONS - Five (5) or 14% were in this category with an average age of 87 years. 40% died outside the hospital after discharge. 40% of the in-house deaths were received from Nursing Homes and 40% were terminal or possibly terminal on admission. This group included various diagnoses of which there were no norms for comparison.

Five (5) of all cases reported expired outside the hospital after discharge.
One case was out of county.
The average age of all reported cases was 81 years of age.

The Medical Staff of Clay County Memorial Hospital will continue to perform ongoing reviews to ensure the quality and appropriateness of care. If you or anyone receiving this information has additional questions, please do not hesitate to call.

JOHNNY RICHARDSON, ADMINISTRATOR
CLAY COUNTY MEMORIAL HOSPITAL

Colonial Hills
HOSPITAL

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs/Mesdames:

Attached is our analysis of the mortality information furnished to us which HCFA plans to publish on short term acute care hospitals which treated Medicare patients in 1986.

In my opinion a fifth grader could have put together better mathematics.

Sincerely,

James M. Hunt
Administrator

JMH/bh

Attachment

4330 Vance Jackson Road ■ San Antonio, Texas 78230 ■ (512) 341-5131

Psychiatric Institutes of America
A subsidiary of National Medical Enterprises, Inc.

Colonial Hills
HOSPITAL

October 26, 1987

Medicare Provider #450629

1. This hospital is a private facility providing inpatient services for the treatment of psychiatric and/or substance abuse disorders.

2. This eighty-two-year-old male patient was admitted to this hospital with a primary diagnosis of Chronic and Severe Alcoholism and Severe Dementia with a secondary diagnosis of emphysema. During his hospitalization and after consultation with an Internist and Neurologist, it was determined that the patient's dementia and continued failing health was substantial enough to prevent the patient from benefiting from further treatment for his alcoholism.

3. After consulting with his family, it was decided to discharge the patient to a nursing home near his family. The patient subsequently passed away within 30 days of discharge from this facility.

4. During calendar year 1986, the hospital experienced 94 Medicare admissions, this case representing 1.04% of the total Medicare admissions for that year. To assume that a 1.04% mortality experience can somehow be translated into a "Range of Predicted Mortality Rates" of up to 16% is at best ridiculous, at worst, gross misrepresentation of statistical data. To project a potential mortality rate 15.4 times greater than actual can only be explained as irresponsible mathematics, not poor medicine.

4330 Vance Jackson Road ■ San Antonio, Texas 78230 ■ (512) 341-5131

Psychiatric Institutes of America
A subsidiary of National Medical Enterprises, Inc.

Colonial Hospital

October 26, 1987

Mr. William L. Roper, M.D.
Administrator
Health Care Financing Admin.
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland, 21207

Dear Mr. Roper:

Enclosed please find Colonial Hospital's comments relative to the HCFA Mortality Data to be published in December of this year.

Sincerely,

Thomas R. Legacy
Administrator

TRL:ls

enclosure

502 West College Terrell, Texas 75160 (214) 563-2671

Medicare # 450175

Comments on HCFA Mortality Data
Colonial Hospital, Terrell, TX

Data Validation

The data as reported by HCFA indicates that a total of 389 Medicare "patients" were admitted to Colonial Hospital in 1986 and of these, 71 patients died within 30 days of admission. Conversely, our own records indicate that a total of 653 "Medicare Admissions" occurred in 1986. Moreover, 56 died while an in-patient and 15 died after discharge. Presumably, this discrepancy is reflected by HCFA's use of "Last Patient Admissions" (389) while the hospital considered the over all "Total Patient Admissions" (653) for the entire year.

Hospital records further indicate that of the 71 reported Medicare deaths, 15 were alive at the time of discharge. It is impossible for the hospital to verify these 15 deaths (after discharge) as these patients most likely went to other acute care facilities, Nursing homes, etc. Without detailed information concerning the available data from HCFA and the methologies used to predict "anticipated mortality ranges", it is impossible to verify the accuracy of the overall data used in the analysis.

While Colonial Hospital's mortality rate according to HCFA falls out of the "predicted range" for all cases (18%), none of the "focused categories" are out of their respective ranges. Furthermore, the reported HCFA data does not provide a reasonable explanation for this outcome. Because the HCFA analysis uses only 389 admissions (patient's last admission) during 1986, the rate of mortality may be interpreted as non-representative and misleading. By using the total number of Medicare admissions (653) and deaths occuring within 30 days of admission, the reported mortality rate would be 10.8%. Again, this methology incompasses the total number of medicare patients actually receiving acute-care at Colonial in 1986 even though as would be expected some patients would have reason to be admitted more than once during this period.

Unique Services Resulting in Higher than Average Mortality

Because there are no Skilled Nursing Facilities within the geographical area, the hospital has been designated with 5 Swing Beds. Several of the deaths occurred under the Swing Bed program and were all anticipated deaths due to the age and severity of the patients illness.

Results of Preliminary Medicare Record Review

Out of the 71 reported deaths, 56 were deaths occurring in the hospital. Four (4) of these were Swing Bed patients, 3 observation and 3 were expirations in the Emergency Room. Fifty-four (54) of the 56 hospital deaths had pre-existing chronic conditions such as Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, Heart Disease to name a few. Forty (40) of the 56 hospital deaths were in acute distress on admission. Sixteen (16) of the 40 died within less than 24 hours of admission.

In 36 of the 56 hospital deaths, death was an "expected outcome". Nine (9) of the 56 were terminal cancer patients with metastasis. Eleven (11) of the 56 patients sustained an acute myocardial infarction (heart attack). Thirteen (13) of the 56 had "Do not Resuscitate" orders issued by the patient and/or family.

The average age of the 56 patients who died at Colonial Hospital was 79 years of age. Ten (10) of the 56 were over 90 years of age. Six (6) were between the ages of 85 to 89. Sixteen (16) were between the ages of 80 to 84. Nine (9) were between 75 to 79. Five (5) were between 70 to 74. Eight (8) between 65-69 with only one less than 65.

The action by HCFA to report mortality data for acute-care facilities may only be construde as informative and providing a needed public service. However, a responsibility lies with HCFA or any other agency to report such information in a way as not to mislead or confuse the public especially people of medicare age. Should this not be realized then the selective reporting of confusing and unexplained data to the public has no real benefit.

Sincerely,

Administrator
Colonial Hospital

TX 111.2

Colorado
Fayette
Medical
Center

October 19, 1987

William L. Roper, M.D.
Healthcare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Department of Health & Human Services
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for this opportunity to repond to the release of data on hospital mortality rates for January 1, 1986 through December 31, 1986. Since receiving the report dated September 21, 1987, the Colorado-Fayette Medical Center's staff has had an opportunity to review the data.

The Colorado-Fayette Medical Center is a 38-bed acute care facility whose patients include many rural elderly people with major medical and surgical illnesses. The Medical Center provides access to medical care for the people of three Texas counties-Colorado, Fayette, Lavaca.

The Medical Center's Quality Assurance Committee composed of Medical Staff members and hospital representatives conduct intensive reviews of the medical records of all patients who expire at this facility in regards to medical management and overall care. Mortality review is an on-going process and is an integral part of the monitoring of the healthcare delivery system at this hospital.

In regards to the specific mortality data reported by the Federal Grovernment, the hospital's review indicates the data to be relatively valid and accurate with only minor discrepancies. Overall, given the very low actual number of deaths in the different categories, the data seems to indicate that on the average the actual mortality rate for the Colorado-Fayette Medical Center falls within the predicted ranges. Of the nineteen deaths reported from strokes, please note that the hospital data verifies only thirteen deaths. Eleven of those deaths occurred while the patient was in the hospital and the average age of those patients was approximately 77.85 years. Nearly all the stroke patients had other medical complications and nealy one-half of the patients had had previous strokes.

400 YOUENS DRIVE • WEIMAR, TEXAS 78962 • (409) 725-9531

The Colorado-Fayette Medical Center of Weimar, Texas will continue to review all deaths for quality and appropriateness in medical care rendered to the patient and will continue to strive for excellence in the delivery of medical care to all patients coming to this hospital.

Thank you for the opportunity to respond to this data. If you or anyone receiving this information has additional questions, please do not hesitate to call us.

Sincerely,

Andrew M. Harris
Chief Executive Officer

AMH:bmg

) BOX L

PHONE 869-5911

Concho County Hospital

EDEN, TEXAS 76837

October 23, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Care Standards & Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

The information you have on the number of admissions, dismissals and deaths at Concho County Hospital is in fact in error. As you stated in your letter there was the possiblity of error in the stastical data. The correct numbers for each category of statistics is as follows:

1986 Medicare
Admissions 234
Dismissals 233

		Percent of total admissions
Deaths from Cancer	2	1%
Deaths from Cerebrovascular accidents	2	1%
Deaths from Gastrointestinal catastrophies	1	.5%
Deaths from Gastrointestinal disease	1	.5%
Deaths from Low risk heart disease	1	.5%
Deaths from Severe chronic heart disease	2	1%
Deaths from Renal Disease	1	.5%
Deaths from other causes	2	1%
Total deaths from all causes	12	5%

Even though the mortality rate shown on your charts is well below the national average, the actual percentage shoud be given if they are to serve any useful purpose.

Sincerely,

Albert M. Everett, Jr.
Administrator/Concho County Hospital

Corpus Christi Osteopathic Hospital

1502 TARLTON • P.O. BOX 7807 • CORPUS CHRISTI, TEXAS 78415 • AREA CODE 512 • 886-2300

OBSTETRICAL, SURGICAL AND MEDICAL SERVICE • Member AOHA-TOHA • Approved Intern Training

October 23, 1987

William L. Roper, M.D.
Healthcare Financing Administration
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the data on hospital mortality rates scheduled for publication in December, 1987.

Our Director of Medical Records, along with the Mortality Review Committee, have validated that, with minor exceptions, the data is accurate.

It should be noted that our hospital medical staff committees monitor every death in our facility on an on-going basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

Again, thank you for the opportunity to present this response.

Sincerely,

Robert R. Tamez
Administrator

RRT/dp

CORYELL MEMORIAL HOSPITAL

AFFILIATED WITH
SCOTT AND WHITE MEMORIAL HOSPITAL

P.O. BOX 659 • 1507 WEST MAIN • GATESVILLE, TEXAS 76528 • 817-865-8251

October 26, 1987 Medicare Provider #450239

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond in advance to the release of the selected mortality data.

Coryell Memorial Hospital is a 55-bed, general acute-care hospital. Services provided by our facility include medical-surgical care, obstetrics, emergency services, and extended care. All of our active Medical Staff members are board-certified in their particular specialties.

The Medical Staff of Coryell Memorial Hospital regularly conducts intensive reviews of all deaths which occur in this facility. Mortality review is an important part of both the Quality Assurance program and the Peer Review activities in our hospital, designed to help insure the delivery of high quality care. Coryell Memorial Hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations, an organization which mandates that quality review be accomplished routinely by the hospital.

The data being released has been reviewed by medical records professionals, the Quality Assurance Coordinator (a Registered Nurse), the Administrator and the Medical Staff. It is felt that the review will assist in setting further direction for our quality review process.

Although the data for Coryell Memorial hospital show that we fall within the predicted rates for all categories, I feel it is important to point out that the data do not reflect an accurate measure of overall quality for any hospital. The model used "assumes" that each hospital's patients are average, except for the few specific characteristics built in, such as sex and age, certain selected complications, etc. It does not consider how ill the patient was at the

time of admission, whether he or she was transferred from a nursing home, or was terminally ill. Additionally, the data apply only to Medicare patients who died within 30 days of admission to the hospital.

Mortality data does, however, offer each hospital one means of helping to insure quality, by serving to focus on peer review and the evaluation of quality.

In reviewing the data being released, we assessed what the percentages mean for Coryell Memorial Hospital. Several factors affect the data, including the high percentage of Medicare patients treated in this hospital (60% in 1986). Further, the average age of those who died was 81.1 years.

Additionally, we found the following:

1) Twenty-six of those who died were terminally ill at the time of admission.
2) The average age of those admitted for severe chronic heart disease(48% mortality rate) was 78.4 years.
3) Twenty-two patients were admitted from a nursing home.
4.) Of those who died after discharge from the hospital, four were in a nursing home, one died in the hospital emergency room, and one died at home.

Finally, the "cause" of death reflected in the data is not always accurate. The "cause" is actually the reason the patient was admitted to the hospital. As an example, a patient admitted for an orthopedic disorder later died of congestive heart failure and prostate cancer, and so the diagnostic category does not always reflect the actual cause of death.

In summary, I feel that the mortality data provide Coryell Memorial Hospital with useful information to enhance our on-going quality and mortality reviews. I also feel that the high percentage of elderly patients with acute illnesses, many of whom are nursing home patients, impacts the data being released.

Again, I thank you for the opportunity to review and comment on this data prior to its release.

Sincerely,

Dick Sweeden

Dick Sweeden
Administrator

DS/se

William L. Roper, M. D.

cc: S. A. Norris, M. D., Chief of Medical Staff

G. N. Lambert, M.D.
Chairman, Tissue and Records Committee

Erle Powell, Chairman of Board of Directors

TX 126.2

Dallas Family Hospital℠
Health for the Whole Family
Dallas Southwest Medical Center
An OSTEOPATHIC Institution

October 22, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

RE: 1986 Mortality Statistics
Provider No. 450094

Dear Doctor Roper:

Thank you for the opportunity to comment on the release by the Health Care Financing Administration of hospital-specific mortality data for Medicare beneficiaries treated during 1986. Since receiving the report on September 24, 1987, the administration and medical staff of Dallas Family Hospital have begun to carefully analyze and consider its implications.

Dallas Family Hospital is a 104 bed general acute care facility located in the southwest part of Dallas, Texas. Like all accredited hospitals, Dallas Family Hospital has always reviewed hospital mortalities as part of its overall review of the medical care provided at the hospital. Our review of your data indicates that the 66 in-hospital deaths is accurate. With regard to the 25 deaths which occurred between one and 30 days after discharge from the hospital, we will require additional time to develop information on cause of death and consider that information with regard to our Quality Assurance program.

As you noted in your letter of September 21, 1987 which accompanied the data release, "the information on its own is not a complete measure of the quality of care at an individual hospital". We will endeavor to utilize the information to the best of our ability, understanding its limitations, in our continuing efforts to ensure that not only Medicare patients, but all hospitalized patients, receive the best possible medical care at our facility.

Thank you very much for the opportunity to make these comments.

Sincerely,

Christopher P. O'Connor
Administrator
Dalias Family Hospital

CPO:st

AMI Danforth Hospital

October 26, 1987

Dr. William Roper, Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Danforth Memorial Hospital, Inc., is a 120-bed acute care facility whose patient mix includes those individuals with major medical and surgical illnesses. We are a general service hospital offering general medicine and surgery areas, along with a physical rehabilitation unit and newly opened extended care facility.

The hospital's specific mortality data reported by HCFA has been carefully reviewed by the hospital administrators, physician chairman of the Utilization Review Committee, Director of Utilization Review and Quality Assurance, and the Director of Medical Records. After careful review of these data, we are pleased to note that the data were reasonably correct, and that Danforth Memorial Hospital, Inc., has no category where the actual mortality rate exceeded the predicted rate.

Danforth Memorial Hospital, Inc.'s quality assurance program includes a detailed review of each patient's hospitalization. The medical record of every patient who expires at this facility is extensively reviewed for appropriate medical management and overall care. This mortality review is an ongoing process of the quality assurance program, and peer review activities are an integral part of the monitoring of the health care delivery system at this hospital. The effectiveness of the quality assurance program is partly responsible for this hospital receiving full accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

Thank you for the opportunity to present this response.

Sincerely,

Carl Abdalian
Executive Director

CA/jdh/Q764

Deaton Hospital, Inc.

208 N. MAIN ST. GALENA PARK, TEXAS 77547 (713) 672-6311

September 28, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Hospital 450440

Dear Sir:

We are submitting the following additional information regarding mortality rates for Deaton Hospital, Inc.:

[redacted] DIAGNOSTIC CATEGORY "UN" - Diagnoses from Death Certificate are: Cardiac/respiratory arrest; Ventricular fibrillation/asystole; Hypoxia, severe; Severe congestive heart failure; Bronchopneumonia; Renal failure. Patient was admitted because of transient cerebral ischemic attacks.

[redacted] DIAGNOSTIC CATEGORY "UN" - Diagnoses from Death Certificate are: Cardiorespiratory arrest; Pneumonia, Klebsiella; Vomiting with dehydration; Congestive heart failure; Carcinoma, prostate, metastatic to vertebrae. Patient was admitted with vomiting and dehydration.

[redacted] DIAGNOSTIC CATEGORY "HL" Diagnoses from Death Certificate are: Cardiac arrest; Ventricular fibrillation/asystole; Arteriosclerotic heart disease; Diabetes mellitus, Type I; Congestive heart failure. Patient did not expire at this hospital but at Eastway General Hospital, Houston, Texas.

[redacted] DIAGNOSTIC CATEGORY "HL" - Diagnoses from Death Certificate are: Cardiac arrest; Acute myocardial infarction; Ventricular fibrillation (arrhythmia); Bronchopneumonia; Renal failure; Anemia. Patient was admitted with hypertension, moderate to severe, acute increase.

[redacted] DIAGNOSTIC CATEGORY "UN" - Diagnoses from Postmortem Examination: Diffuse pulmonary edema and acute bronchopneumonia; Old posterior septal wall myocardial infarction; Calcific atherosclerotic heart disease; Membranous pericarditis; Status post left radical mastectomy. Patient was admitted for acute laryngotracheobronchitis.

Please include this data in the printed mortality information regarding Deaton Hospital, Inc.

Sincerely,

Don D. Nichols

Don D. Nichols, Administrator

DDN/dl
encl

DECATUR COMMUNITY HOSPITAL

October 20, 1987

William L. Roper M.D.
Administrator
Health Care Financing Administration
of the Department of Health and Human Services

Re: Selected Mortality Information Medicare Patients for 1986

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on Hospital Mortality Rates for the year 1986. Since receiving the report dated September 21, 1987, Decatur Community Hospital staff has had an opportunity to review the data.

The Director of Medical Records has validated that with one exception, the data is accurate. The Director of Hospital Quality Assurance has reviewed all cases reflected in this report.

On an ongoing basis, appropriate Medical Staff committees have always reviewed every mortality in our facility for appropriateness of care. In addition, the Director of Medical Records reports to the Medical Staff all known deaths that occur within 30 days of discharge and these too are reviewed by the Medical Staff.

In the diagnostic category of renal disease 2 cases were listed which gave us 100% mortality when the predicted mortality rate was 3 to 91%. In reviewing these two charts, the first was a very elderly patient with metastatic cancer and subsequent renal failure. The second case was a patient with a history of multiple strokes who was admitted and treated for renal failure. The treatment was successful and the patient was discharged, but died 8 days later from pneumonia, complicated by another stroke.

The Medical Staff of the Decatur Community Hospital has and will continue to review all mortality cases for quality and appropriateness of care rendered. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Sincerely,

Joseph F. Sloan
Administrator

JFS/ag

2000 South FM 51 Decatur, TX 76234
Decatur (817) 627-5921 Fort Worth-Dallas 430-0863

DOCTORS HOSPITAL

October 26, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to provide input on the HCFA mortality data release for CY 1986 prior to public disclosure.

Doctor Hospital is a 278 bed acute care facility providing major medical and surgical services to our community for 28 years.

As a routine standard of care, our medical staff reviews a representative number of all patient admissions and conducts an intense review of the medical record of every patient who expires at this facility.

The Director of Medical Records has validated that the data reviewed is acurate, although the study by design does not include all 1986 admissions for those patients who expired.

It should be noted that hospital results are all within predicted mortality ranges. The hospital would like to comment on two specific diagnostic categories:

- GASTROINTESTIONAL CATASTROPHES

  Of the 13 patients who expired at Doctors Hospital, medical staff review indicated that 11 patients suffered from multiple medical problems prior to hospital admission.

  Seven of the thirteen patients had previous admissions in 1986, thereby indicating chronic health problems.

- PULMONARY DISEASE

  Of the 48 patients who expired at Doctors Hospital, medical staff review indicated that 45 patients suffered from multiple medical problems prior to hospital admission. In many instances,

9440 Poppy Drive • Dallas, Texas 75218 • Telephone 214-324-6100 • A National Medical Enterprises Health Care Center

the pulmonary disease responsible for the latest hospital admission was secondary to the various pre-existing conditions which have an unpredictable impact upon the patient's health.

The average age of the forty-eight patients was 82 years and 22 of 48 had previous admissions in 1986. These factors indicate chronic health problems.

We hope that this information is helpful.

Should you have any questions regarding our comments, please feel free to contact us.

Regards,

Christopher DiCicco
Executive Director

Michael Gidcomb, M.D.
President of the Medical Staff

Harris Methodist
Dublin

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the Mortality Statistics for 1986. Our medical staff and quality assurance committee have reviewed your data and found that it compares well with our own data. A part of our on-going commitment to quality patient care, your data provides another tool with which we can focus our efforts in this area.

Harris Methodist Dublin is a 36 bed primary care hospital which strives to deliver the best possible care to all patients. In addition to our acute care hospital we also provide special services such as the Swing-Bed Program. We believe that providing these services and caring for the sick is our community obligation.

The medical staff reviews the records of every patient who expires in our facility with regard to their medical management and overall care, and such reviews are an integral portion of our overall Quality Assurance Program which monitors many aspects of healthcare at our hospital.

A review was made of charts in the area of cancer, gastrointestinal catastrophes and diseases, gynecologic diseases, orthopedic disorders, and severe trauma. The low mortality rate in these areas was a result of the more severe cases being transferred to the large tertiary care centers or to physicians that specialize in these procedures.

The medical staff and administration of Harris Methodist Dublin will continue to review patient care for quality and appropriateness because such review is part of an on-going commitment to maintain and improve healthcare. Again, thank you for the opportunity to respond.

Sincerely,

John D. Hodges , Administrator

A member of
Harris Methodist Health System

205 North Patrick / P.O. Drawer O / Dublin, Texas 76446 / 817-445-3322

FAMILY HOSPITAL CENTER
2828 West 27th Avenue • Amarillo, Texas 79109 • 806/358-3131

October 23, 1987

Attention: William L. Roper, M.D.

Thank you for the opportunity to respond to the mortality data and statistics concerning our facility.

Our Director of Medical Records has reviewed the data and confirms this information to be accurate.

Family Hospital Center is a 50-bed general-acute care facility located in Amarillo, Texas. We are the smallest hospital in the city which has three other public hospitals totaling 1,062 beds. Although our hospital has MD physicians on staff, the majority of our medical staff are osteopathic physicians (DOs).

Approximately 65 percent of our patients are Medicare funded. A large number of these are transferred from local nursing homes.

In a survey of 14 nursing homes in Amarillo, which totalled 1,276 beds, Family Hospital physicians were responsible for the patient care for approximately 49 percent of the nursing home residents.

For 1986, Family Hospital was attributed by the Health Care Financing Administration for 56 Medicare patient deaths. Of these, 35 were actual in-house mortalities and 21 deaths occurred outside of the hospital.

Of the 56 Medicare deaths, our Medical Records personnel were able to document that 40 (71 percent) of these had directions to either "No Code" (do not resuscitate) or Chemical Code Only (use only medication to resuscitate).

Despite the moral and ethical issues involved here, our staff honored and respected the personal decisions and wishes of the patients and/or their families.

As mentioned, the majority of these deaths were nursing home residents. Of the 35 Medicare in-hospital deaths, 24 (68.5 percent) were transferred here from local nursing homes. Of the 21 deaths that occurred outside the hospital, 18 (85 percent) of these patients were discharged back to nursing homes. The average length of stay for these patients was 7.3 days.

The overall mean age of the 56 mortalities was 80.6 years. Approximately 52 percent of the deaths were between the ages of 80 and 99 years.

Over 70 percent of our mortalities were categorized as high-risk (according to HCFA standards). However, we feel three of our low risk deaths should have been classified as in the high-risk category. Nonetheless, Family Hospital's low-risk deaths remained at less than 9 percent.

As has been the policy for a number of years at this hospital, the hospital's Executive Committee, consisting of seven of our medical staff members, reviews mortality data every month. We will continue this practice of monitoring and examining each death, including Medicare patients.

Though this hospital did not have any outstanding outliers, either high or low, the mortality rate of 17 percent, (which is still within HCFA predicted mortality standards of 11 to 20 percent), is not an accurate measurement. It did not take into account the other 34 previous admissions by these 56 patients.

If HCFA were using the same mortality rate formula as it did in the previous study, it would note that Family Hospital's rate has declined from 10.1 percent to 6.7 percent.

We urge the Health Care Financing Administration to continue to improve the accuracy of its mortality formula. Additional data such as previous Medicare admissions, severity of illness, and case mix would help in your measurement of mortality. However, we feel this by itself, is by no means an accurate indicator of quality at any hospital. That is an individual decision. Again, thank you for the opportunity to voice our comments.

Sincerely,

Rodney Bailey

Rodney Bailey,
Administrator

FANNIN COUNTY HOSPITAL

October 11, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Information
P.O. Box 26554
Baltimore, Maryland 21207

Dr. Roper:

Thank-you for the opportunity to provide input on the mortality statistics for patient discharges for calendar year 1986. Our hospital is a 85-bed acute care facility serving the Fannin County area of North Central Texas.

The Medical Staff of our hospital monitors every death that occurs. This monitoring system provides continuous feedback on the quality of care provided by our staff. The system is an integral part of our effort to meet and exceed quality of care standards.

The HCFA mortality statistics display our mortality experience as being within predicted ranges for mortality for our patient population. The predicted range was established by assessing the risk of death for a similar patient population by risk factors of age, sex, and cause for admission, presence of additional disease, total of prior hospitalizations, and status as a patient transferred from another hospital.

While the mortality data alone would not be a full measure of the quality of care in a hospital, the categories of patients used in the data were selected to reflect the major causes of hospitalization for Medicare patients. This information may be useful to consumers. It is in this spirit of seeking excellence that our facility will utilize the HCFA Mortality Data in monitoring the healthcare delivery system at our hospital.

Sincerely,

Michael Moseley
Administrator

504 LIPSCOMB BLVD. BONHAM, TEXAS 75418 214-583-8585

FORT WORTH
OSTEOPATHIC MEDICAL CENTER
1000 Montgomery Street • Fort Worth, Texas 76107 • 817/731-4311

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to Fort Worth Osteopathic Medical Center's mortality statistics for January 1, 1986, through September 30, 1986. Our staff, coordinated by the Director of Medical Records and Chief of Medical Staff, has reviewed the data since its receipt, and would like to clarify a few points.

Overall, we commend your study for its accuracy. Your records showed a total of 216 HCFA mortalities, while our records showed 214. Total in-house expirations, according to your records, were 178. Our records indicated 176.

Our rates were within all HCFA projected mortality rates for specific categories. However, the predicted percentage of deaths overall was between 9 and 16 percent. FWOMC had a rate of 17 percent. After a thorough audit of the data, we conclude that our overall mortality rate was higher than predicted because:

Almost all patients in question were admitted with in poor to severe conditions, and more than one third were admitted with "Do Not Resuscitate" instructions, at the request of their families.

A high percent were admitted from nursing homes, and the severity of their illnesses was complicated by their sedentary lifestyles.

In 1986, our hospital was able to accept and treat more severely and terminally ill patients than we previously were able to handle.

Of the total HCFA mortalities, 178 expirations occurred in-house. The average length of stay was 8.1 days. Of great significance is that of that total, 42 patients, or 24 percent, died within 24 hours of admission.

The most important factor in our research was that 91 percent of patients who later expired were graded poor to serious upon admission. Only 9 percent were admitted as fair. This should be coupled with the fact that 31 percent were admitted with "Do Not Resuscitate" instructions, at the request of their families.

A secondary factor which should be considered is the source of the admission. A total of 59 percent of patients who expired were admitted from a nursing home. Additionally, 37 percent came from home. Of those admitted from home, more than one-third were admitted with a terminal cancer.

One final item of note is that 1986 was the first full year of our CCU and telemetry units. We were able to accept and care for a greater number of severely and terminally ill patients than we previously had been able to accept.

Therefore, we believe our mortality rates are well within projected norms, when the admitting condition, prognosis, and expected outcome of those patients is taken into consideration.

Fort Worth Osteopathic Medical Center has a Mortality Committee, consisting of physicians, which reviews all expirations on a monthly basis to assess conditions of expiration. FWOMC also has an excellent Quality Assurance program to evaluate physician performance and take corrective action where indicated. We believe these steps allow us to continue to provide the quality care that both HCFA and our patients expect.

Sincerely,

John P. Hawkins

John P. Hawkins
Executive Vice President

Medicare Provider Number: 450121

GARLAND
COMMUNITY
HOSPITAL

October 21, 1987

Dr. William L. Roper
Health Standards & Quality Bureau
Mortality Rate Information
6325 Security Blvd.
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for January, 1986 through December, 1986 prior to public disclosure.

Garland Community Hospital is a 128 bed acute care facility that provides care for hundreds of patients with major medical and surgical illnesses each year. The Medical Staff conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality Review and Physician Peer Review activities are an on-going process of the Quality Assurance program and an integral part of the monitoring of quality care at this hospital.

The specific mortality data reported by HCFA has been carefully reviewed by the Director of Medical Records, Director of Quality Assurance, Director of Utilization Review, Administration, and the Chairman of Medical Care Evaluation Committee. Our overall percentage of mortalities fall well within the range of predicted mortality rates set by HCFA. In three (3) categories the hospital's actual mortality rate exceeded the midpoint of the range. The presence of multiple chronic conditions, the request for no heroic measures on 63% of the cases, and the small sample size are elements that should be taken into account when reviewing these categories.

The Medical Staff at Garland Community Hospital will continue to review all mortality cases in an endeavor to identify opportunities to continue to meet and exceed quality care standards.

Again, thank you for the opportunity to present this response.

Sincerely,

Kevin J. Hicks
Administrator

Kanti Agrawal, M.D., Chairman
Medical Care Evaluation Committee

122 SOUTH INTERNATIONAL ROAD GARLAND, TEXAS 75042 214/276-7116

GASTON
EPISCOPAL HOSPITAL
3505 GASTON AVENUE
Dallas, Texas 75246

October 27, 1987

Department of Health & Human Services
William L. Roper, M.D.
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

The following information for Gaston Episcopal Hospital is to be attached to the HCFA mortality data for 1986.

Gaston Epsicopal Hospital is a 104 bed general medical and surgical facility, offering speciality care in the area of major orthopedic services.

The Medical Staff of Gaston Episcopal Hospital reviews the medical record of every patient who expires at this facility, focusing on medical management and overall quality of care. Mortality review is an on-going process of the Quality Assurance program, and peer review activities are an intergal part of the healthcare delivery monitoring system of this hospital.

The hospital specific mortality data reported by HCFA has been validated by the Director of Medical Records and carefully reviewed by the hospital Administrator, the Coordinator of Quality Assurance and the Medical Staff. The actual mortality rates in all categories of Medicare admissions fall within or below the range of predicted mortality rates for this facility, the average age at time of death being 79.5 years.

Thank you for the opportunity to respond to this data release. The Medical Staff of Gaston Episcopal Hospital will continue to review all mortality cases for appropriateness and quality of care in an ongoing endeavor to identify opportunities to improve care.

Sincerely,

George S. Schools M.D.
George S. Schools, M.D.
President of the Medical Staff

Charles M. Cooper
Charles M. Cooper
Administrator



General Hospital of
LAKEWOOD
The best of the past ~ and future ~ today.

October 22, 1987

Dr. William L. Roper, M.D., Administrator
Department of Health and Human Resources
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

I am writing in response to your letter on plans to publish selected mortality information for all short term acute care hospitals.

The DRG Coordinator and Director of Medical Records have validated that the data appears to be accurate.

Our hospital medical staff committees routinely monitor every mortality in our facility for appropriateness of care. We feel that as a small, acute care hospital we are able to provide a unique, individual and comprehensive care for our patients.

Thank you for the opportunity to respond to the mortality data.

Sincerely,

Steven D. Porter
Administrator

Kawasaki M.D.

Masashi Kawasaki, M.D.
President - Medical Staff

SDP:bb

1600 Abrams Road Dallas, Texas 75214 Phone (214) 824-4541

GEORGETOWN HOSPITAL

KENNETH W. POTEETE
PRESIDENT/CEO

October 20, 1987

2000 SCENIC DRIVE
GEORGETOWN, TEXAS 78626
512/863-6531 / 255-7883

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. ~~Box~~ 26684
Baltimore, Maryland 21207

Dear Sir:

The following information for Georgetown Hospital is to be attached to the Hospital Specific Report for the period January 1, 1986 through December 31, 1986 prior to public disclosure.

Georgetown Hospital is a 66 bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. Care offered to Medicare recipients is in the specialty areas of, major orthopedic, and urology as well as general medicine and surgery.

The Medical Staff at Georgetown Hospital conducts an intensive review of the medical record of each patient, not only those who expire, regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital. Georgetown Hospital is fully accredited by the Joint Commission on Accreditation of Health Care Organizations. Recently, the survey team of JCAHCO were very complimentary of the hospitals Quality Assurance Program and the excellent peer review process that is being performed.

The hospital specific mortality data reported by HCFA has been carefully reviewed by the hospital administrator, President of the Medical Staff, Physician Chairmen of all clinical departments, the Quality Assurance Committee and the Director of Medical Records. Our internal data indicates the hospital's overall percentage of deaths, per admission, is approximately 2.9%.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

The information you provided to our facility agrees with data compiled at our institution except for one case which was listed twice. (Same medicare number, and dates, but different names.) See attached.

As previously stated, review by this facility is always by individual case, regarding overall quality of care, and is conducted in an on-going fashion not just when statistics such as the mortality data are released.

Thank you for the opportunity to present this response.

Sincerely,

Kenneth W. Poteete
President, CEO

Steven Schaefer, O.D.
Chairman, Governing Board

Bob Gaddy, M.D.
President of the Medial Staff

KWP/pmb

Enc. 1

GOOD SHEPHERD
MEDICAL CENTER

621 NORTH FIFTH STREET
LONGVIEW, TEXAS 75601
214/236-2000

October 21, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to offer our comments on the mortality statistics for the year of 1986.

We have reviewed the statistics you have released for our hospital. There were fifty-two patients that expired after discharge from our facility. In addition, we found one patient named twice in our statistics.

While Good Shepherd Medical Center (GSMC) falls well within the acceptable mortality ranges, we do not believe these statistics to be valid quality indicators. There are many variables that affect these numbers including complication of the illness, age, socio-economic status, and sex. GSMC monitors all deaths as a part of our Quality Assurance Program to determine appropriate medical management and overall care.

As a result of our Quality Assurance Program and accreditation by the JCAH, we know that GSMC provides excellent medical care to our community and referral areas.

Again, we thank you for this opportunity.

Sincerely,

Jerry Adair
President

JA/jv

Graham General Hospital

Patrick L. Wallace, Administrator

P.O. Box 1390
Graham, Texas 76046
(817)549-3400

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Comments on HCFA Mortality Data
Graham General Hospital, Graham, Texas

Dear Sirs:

The publication of mortality data from this hospital by HCFA is a public disservice. The data is inaccurate, misleading, invalidated and probably meaningless. The statistical model used by HCFA to calculate the range of predicted mortality rates has several major flaws that make all predictions drawn from it questionably reliable. The five patient characteristics considered in the model may not be the most significant characteristics influencing the risk of death. It fails to consider the many factors relating to the risk of death, e.g., severity of illness, patient's general health status, stage of illness, and patient's mental and psychological status. Even more important is the fact that this model has not been validated or tested in any way. The published mortality rates may differ from the predicted range because of some of the factors listed above, problems arising during treatment, or other unknown causes. The fact that HCFA will not release the formula by which the predicted mortality rates were figured raises the suspicion that it is concerned about how the formula would fare under close scrutiny by parties outside the government.

Notwithstanding the above caveats, the published data demands comment. The mortality rate for Graham General Hospital for all causes is wrong because 13% of the patients included were admitted to and died in other hospitals after being in Graham General Hospital. The inclusion of these patients causes error in one or two other diagnostic categories, though the information to determine which ones is not available. Even with the incorrect inclusion of 13% of patients, the mortality rate for Graham General Hospital falls within the predicted range. A recent detailed Medicare survey found no major deficiencies in the hospital, and the survey team commented that the care being given and particularly the quality assurance program was very good.

Sixteen patients died within 30 days of discharge. Of those, 19% died of causes unrelated to the disease for which they were hospitalized. All of the other deaths were expected by the attending physician due to the patients overall physical condition or the stage or nature of the disease.

The only diagnostic category where Graham General Hospital's mortality rate was outside the predicted range was sepsis. Of those patients, all except one death was expected at the time of admission due to the severity of the disease, the overall medical or mental condition of the patient and/or the patient's/family's request to withold vigorous treatment.

The only unexpected death was due to a pulmonary embolus that may or may not have been related to the admitting diagnosis of sepsis.

It is clear that the validity and therefore the reliability of the data is highly suspect. It is also important to note that for Graham General Hospital, Medicare patients represent only 32% of the total admissions. If the data release is intended to be an indicator of quality of care, then the sample is too small and narrow in scope to be significant. Dr. William L. Roper, Administrator of HCFA, has stated "The quality of health care in the nation will be better off..." because of the publication of this data. While that is a noble goal, it is doubtful that spending enormous sums of money to capture, evaluate, publish and distribute faulty data effectively addresses that goal.

Respectfully yours,

C. E. Oswalt, M.D.

Charles E. Oswalt, M.D.
President, Medical Staff

Patrick L. Wallace

Patrick L. Wallace
Hospital Administrator

CEO:ajh

COMMENTS ON THE HCFA MORTALITY DATA

HCA Gulf Coast Hospital
Baytown, Texas 77520
Provider No. 00450027

October 23, 1987

DATA VERIFICATION

The data used by HCFA indicate that a total of 96 Medicare patients admitted to Gulf Coast Hospital died within 30 days of admission. Of these, 77 died while still a patient in the hospital, while 19 died after discharge, assuming the latter figure is correct. Our own records indicate that 914 Medicare admissions occurred in 1986 and this figure does reflect multiple admissions for the same patient. We have no way of verifying whether the number of Medicare patients treated at Gulf Coast HOpsital is correct, based solely on the final admission. It is also impossible to verify the number of patients dying after discharge, since follow-up information concerning the death of a patient after discharge is not routinely recorded in a patient's record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis. However, the lack of certain factors which significantly impact mortality such as the patient's general physical and psychological health status, the stage or severity of the patient's illness and the presence or absence of family support---factors which can only be ascertained by reviewing a patient's medical record---tends to moderate the validity of the predicted mortality rates, as does use of the principal diagnosis rather than the actual cause of death in assigning patients to diagnostic categories.

INTERPRETIVE REMARKS

In two of the diagnostic categories, the hospital's actual mortality rate falls outside the range of the predicted mortality rate. Severe chronic heart disease and severe acute heart disease. Several factors may account for these differences, as follows:

Severe Chronic Heart Disease- Of 17 total patients, 14 died in the hospital; and, presumably, 3 post discharge. Eight patients died within 48 hours of admission; five of these were qualified as "do not resuscitate" patients. In at least two cases, the underlying cause of death was cancer, yet reason for admission was cardiac related.

2800 Garth Road
Baytown, Texas 77521
Telephone (713) 425-9100
A subsidiary of HCA The Healthcare Company

HCA - Gulf Coast Hospital
Baytown, Texas 77521
October 23, 1987
Re: Mortality Rates

Severe Acute Heart Disease -Of 11 patients, 10 actually died in the hospital, with 1 reported death post-discharge. Eight of these patients expired within 48 hours of admission, two having been transferred from nursing home. Three represented "do not resuscitate" cases. Underlying cause of death in one case was pulmonary disease and in another cancer; both assigned to severe acute heart disease category, based on principal diagnosis.

UNIQUE CIRCUMSTANCES RESULTING IN HIGHER THAN AVERAGE MORTALITY

Gulf Coast Hospital experiences high volume family practice patients in a community with three unskilled nursing home facilities and a shortage of skilled beds. Currently there are ten active family practitioners, each of whom treats geriatric patients, three of these physicians maintain significant nursing home patient loads. Local community norms result in higher than average mortality rates due to nursing home patients being admitted to the hospital when close to death.

The hospital provides oncology services to a limited extent. However, the majority of cancer patients in the area are referred to metropolitan medical center for agressive treatment, significant numbers are supported with chemotherapy and other palliative modalities at this facility during terminal stages of their disease.

The hospital also draws from surrounding rural communities with high elderly populations.

OTHER COMMENTS

The hospital's quality assurance program dictates physician review of all death cases. During 1986 the medical record of every death was examined by a physician committee. There were no trends or patterns identified indicating substandard care. IN addition the Texas Medical Foundation examines all death cases of Medicare patients and records screened against quality of care criteria. To our knowledge, there were no issues raised by the TMF-PROT as relates to quality of care administered by our physicians or hospital as a result of this review for the year 1986.

Linda Hischke
Linda Hischke
Administrator

[redacted]

GULF COAST
MEDICAL
CENTER

October 22, 1987

William L. Roper, M.D., Administrator
Healthcare Financing Administration
Health Standards and Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to provide input on the mortality statistics for the year 1986.

Gulf Coast Medical Center is a 161-bed acute care facility serving a large, rural geographic area. Our case mix index includes patients with major medical and surgical illnesses. We are a full service medical center offering care in the specialty areas of oncology and dialysis as well as general medicine and surgery.

Our hospital medical staff committees monitor every death in our facility on an on-going basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

We have been unable to identify one patient included as a death related to our facility. We have no record or evidence that this patient was ever admitted to this facility.

We are pleased that the reported data confirm our own findings that Gulf Coast Medical Center provides a level of care consistent with the predicted ranges of patient mortality. We also recognize that these data cannot be utilized in comparing individual hospitals due to the variations of case mix indices, service mix and referral patterns.

Thank you for providing the nation's hospitals the opportunity to review their data and submit comments prior to publication.

Sincerely,

L. Gene Matthews

L. Gene Matthews, Administrator

P.O. Box 3004
Wharton, Texas 77488
Telephone (409) 532-2500

An Affiliate of
HEALTHTRUST
INC. The Hospital Company

HARRIS COUNTY HOSPITAL DISTRICT

DISTRICT ADMINISTRATION
726 GILLETTE
HOUSTON, TEXAS 77019
652-1200

BEN TAUB GENERAL HOSPITAL
1502 TAUB LOOP
HOUSTON, TEXAS 77030
791-7000

COMMUNITY HEALTH PROGRAMS
726 GILLETTE
HOUSTON, TEXAS 77019
652-1240

JEFFERSON DAVIS HOSPITAL
1801 ALLEN PARKWAY
HOUSTON, TEXAS 77019
751-8000

P.O. BOX 66769 - HOUSTON, TEXAS 77266 (713) 751-8500

October 15, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: MORTALITY RATES - HOSPITAL PROVIDER NUMBER 45-0289
JANUARY 1, 1986 - DECEMBER 31, 1986

Dear Dr. Roper:

The following information for Harris County Hospital District (provider number 45-0289) is to be attached to the Hospital Specific Report for the period January 1, 1986 through December 31, 1986, prior to public disclosure.

The Harris County Hospital District (the District) operates three institutions (816 beds), eleven community health centers, and a level I trauma center all located within Harris County, Texas. The District was formulated in 1965 under Texas Statute 4494n and was charged with the care of the indigent and emergent population of Harris County, Texas. The District is a full service provider of primary and acute care offering care in the wide spectrum of major and minor medical and surgical care.

Although the District's overall actual mortality rate exceeds the nationwide range of predicted mortality rates, one must note that until additional data elements are added to the mortality database, such as severity of illness and a broad spectrum of socio-economic measures, HCFA does not recommend the use of this information to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals.

Approximately 96% of the District eligible Medicare patients are of the indigent population base of Harris County. The vast majority suffer from several chronic disorders which

raises the acuity level (or intensity of illness) of the patient. Many of these patients suffer from comorbid conditions such as diabetes, hypertension, chronic pulmonary disorders, etc. which, compounded with an acute illness episode, creates an intensely ill elderly patient.

Over 70% of the District's Medicare admissions occur through the Ben Taub Emergency Center and, of this percentage, many enter the hospital due to severe trauma. In many instances a patient which normally would be considered DOA is revived and expires within forty-eight (48) hours of the admission. This factor was not considered in the development of the mortality factors.

It has also been noted through studies conducted by District personnel and the Baylor College of Medicine that of the male minority population (Hispanic and Black), individuals from these socio-economic backgrounds wait to enter the hospital setting for treatment when the nature of the illness is highly intense with many complicating factors. This situation has a significant bearing on the mortality of the individual which is not considered within the mortality statistic.

Although the District delivers both primary and acute care for District eligible Medicare beneficiaries enhancing the overall health status of the patient, there are a number of patients in the HCFA mortality study which were first seen by the District on the admission which the patient expired. Also, of the thirty-seven (37) patients who expired outside of the hospitals, several expired due to a condition not related to the previous hospitalization..

Of the sepsis cases reported by HCFA, the patient data base submitted by HCFA included nine (9). The seven (7) admissions where patients expired a diagnosis of sepsis was made at the time of admission. All patients within this group had three or more chronic high risk comorbid conditions which directly affected the patient's grave prognosis. These conditions included diabetes, renal disease, hypertensive disease, cerebral degeneration, chronic pulmonary disease, angina, metabolic acidosis and electrolyte imbalance, and GI bleeding. Other significant conditions common to this group were pneumonia, dyspnea-intubation, extremely elevated temperatures, dehydration, and multiple decubiti. Three (3) patients expired within forty-eight (48) hours after admission in spite of early medical intervention.

The remaining four (4) were treated appropriately; however, due to the severity of their illness and the many underlying conditions that also required treatment, they suffered cardiopulmonary arrest prior to stabilization of all of their disorders. In six (6) out of the seven (7) cases, at the wish of the patient's family, mechanical resuscitation was not to be performed should cardiac arrest occur.

The District takes pride in the quality of care given to the indigent population of Harris County, Texas. The District has and will continue to be fully accredited by the Joint Commission of Accreditation Healthcare Organizations (JCAHO). High standards of quality in patient care are of foremost importance with District personnel and Baylor practicing staff.

The District thanks the Health Care Financing Administration for this opportunity to present this response.

Very truly yours,

Richard L. Durbin
Chief Administrator

George L. Jordon, Jr., M.D.
Chief of Staff

RKH:RLD:dn

xc: Texas Hospital Association
Greater Houston Hospital Council
Texas Association of Public & Non-Profit Hospitals

Harris Methodist
Fort Worth

October 23, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Re: Mortality Data

Dear Dr. Roper:

Thank you for the opportunity to respond to HCFA's 1986 mortality statistics. Our medical staff and quality assurance personnel have reviewed the data and found it compares well with our own internal data. As part of our ongoing quality assurance process, the medical staff at Harris Methodist Fort Worth intensively reviews the medical records of every patient who expires regarding appropriateness of care. Your data will significantly complement our continuous efforts to perform this review.

Harris Methodist Fort Worth is a 628 bed tertiary care center whose case mix includes many patients with major medical and surgical illnesses. Harris provides a full range of health care services with speciality areas in open heart surgery, major orthopedic surgeries, trauma, endstage renal disease, neuro surgery, oncology and rehabilatative medicine.

HCFA's 1986 mortality data has been carefully reviewed by officers of the medical staff, the chiefs of the appropriate medical services, the director of utilization review and quality assurance, the director of medical records, and hospital administration. In all 16 categories, as well as overall, Harris' Medicare mortality rates fell within HCFA's predicted ranges.

The following presents some of the pertinent factors affecting overall mortality rates for Medicare patients who expired at Harris Methodist Fort Worth:

- 25% of patients were admitted from another health care facility because their conditions warranted transfer to a specialty care hospital.
- 67% were admitted from the emergency room due to the urgency of their condition.
- Approximately one-third of patients or their families requested no heroic medical effort be initiated for the categories of low-risk heart disease, sepsis, and severe chronic heart disease.

A member of
Harris Methodist Health System

1301 Pennsylvania Avenue / Fort Worth, Texas 76104 / 817-882-2000

The Medical Staff and Administration of Harris Methodist Fort Worth has and will continue to review patient care for quality and appropriateness because such review is part of our ongoing commitment to maintain and improve health care. Again, thank you for the opportunity to respond.

Sincerely,

Charles M. Brosseau, Jr.
Senior Vice President/Administrator

Leroy Bursey, M.D.
Chief of Medical Staff

CMB/LB/wm

Harris Methodist
H·E·B

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for the opportunity to provide input on the mortality statistics for 1986. Our medical staff has always reviewed mortality cases at Harris Methodist H.E.B for appropriateness of care. Your data provides additional opportunities not previously available and suggests additional direction for research into quality issues.

The information provided by your office has been verified with medical records and is essentially correct. The overall rate, as well as the rates within all of the diagnostic categories, were well within the predicted ranges. Several comments are in order regarding the following categories:

- Severe Acute Heart Disease:

  23 deaths were assigned to this category. Of these: 96% were admitted through the emergency room; and 43% were considered terminally ill at the time of admission.

- Pulmonary Disease:

  12 deaths were assigned to this category. Of these: 75% were admitted through the emergency room; 75% were considered terminally ill at the time of admission.

- Gastrointestinal Disease:

  7 deaths were assigned to this category. Of these: 57% were admitted through the emergency room; 100% were considered terminally ill at the time of admission.

- Sepsis:

  3 deaths were assigned to this category. Of these: 100% were admitted through the emergency room; 67% were considered terminally ill at the time of admission.

A member of
Harris Methodist Health System

1600 Hospital Parkway / Bedford, Texas 76022-6913 / 817-283-1561

It is also significant to note that all of the patients assigned to the above categories had additional and significant pre-existing health complications.

Extensive review of these records by the medical staff indicates that the level and quality of care was appropriate in all cases.

The medical staff and administration of Harris Methodist H.E.B will continue to review all cases against such criteria and will welcome and encourage all efforts that focus on quality care.

Sincerely,

Robert E. Karper, M.D.
Chief of Staff

R. William Whitman, Jr.
Senior Vice President/Administrator

REK:RWW:ns

Harris Methodist
Mexia

October 23, 1987

Dr. William R. Roper
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear. Dr. Roper,

Thank you for the opportunity to respond to the mortality statistics for 1986. Our Medical Staff and Quality Assurance Committee have reviewed your data and found that it compares well with our own data. As part of our on-going commitment to quality patient care, your data provides another tool with which we can focus our efforts in this area.

Harris Methodist Mexia is a 77 bed primary acute care hospital which strives to deliver the best possible care to all patients. In addition to our acute care hospital, we also provide special services such as cardiology, gastroenterology, ophthalmology, pulmonary medicine and urology. We believe that providing these services and caring for the very sick is our community obligation.

In reviewing our charts in the area of renal disease and severe acute heart disease, we have found that the average age of the deceased patients was 76 years of age and that the outcome of the cases was expected. This severe expectation is based on the fact that these patients presented with multiple diseases which compromised their ability to overcome the renal or acute heart disease. The medical staff reviews the records of every patient who expired in our facility with regard to their medical management and overall care and such reviews are an integral portion of our overall quality assurance program which monitors many aspects of health care at our hospital.

In further review of our charts in the area of pulmonary disease, we have found that the average age of the deceased patients was 82 years of age and the outcome of the cases was expected. However, it should be noted that frequently these types of patients are transferred to tertiary care facilities which have both greater diagnostic and treatment capabilities. This practice may have artificially lowered the actual mortality rate.

The Medical Staff and Administration of Harris Methodist Mexia will continue to review patient care for quality and appropriateness because such review is part of an on-going commitment to maintain and improve health care in our community. Again, thank you for the opportunity to respond.

Respectfully submitted,

D. Crawford Allison, M.D.
Chief of Staff

Roger T. Jenkins
Administrator

A member of
Harris Methodist Health System

312 East Glendale / Mexia, Texas 76667 / 817-562-5332

Harris Methodist
Northwest

October 23, 1987

Dr. William L. Roper
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Medicare Mortality Statistics

Dear Dr. Roper:

Thank you for the opportunity to respond to the Medicare Mortality Statistics for 1986. Our Medical Staff and Quality Assurance Committee have reviewed your data with the following results.

As part of our on-going commitment to quality patient care, your data provides another tool with which we can focus our efforts in this area. Our Medical Staff reviews the record of every patient who expires in our facility with regard to their medical management and overall care, and such reviews are an integral portion of our comprehensive Quality Assurance Program which monitors all aspects of healthcare at our hospital.

Harris Methodist Northwest is a 48-bed primary acute care hospital which strives to deliver the best possible care to all patients. In addition to our acute care hospital, we also provide emergency services to a large suburban and rural area northwest of Fort Worth. We believe that providing these services and caring for the very sick in our community obligation.

Thanks in part to the availability of a tertiary care center less than 20 miles away, we transfer a large number of patients for further diagnostic and therapeutic measures. As a result of Medicare's methodology of

A member of
Harris Methodist Health System

108 Denver Trail / Azle, Texas 76020 / 817-444-2575

computing death rates, these patients are not included in the patient population for Harris Methodist Northwest. If these patients were included in the computation for Harris Methodist Northwest, the overall death rate for Medicare patients would be less than 15%, a statistically significant drop from the data compiled by Medicare for public release.

For example, if two patients suffer heart attacks and are brought in to the emergency room at Harris Methodist Northwest and one patient is stabilized and transferred but the other dies, the current Medicare methodology of computing the death rate would indicate a 100% death rate, in spite of the fact that one patient survived. We understand the difficulties involved in defining an equitable methodology for computing the mortality rates for hospitals nation-wide and feel it is unfortunate that the current methodology, as it applies to Harris Methodist Northwest, is misleading.

Medicare patients represented only 31% of the patients cared for at Harris methodist Northwest in 1986. However, we take our responsibilities to provide high quality care to all patients very seriously. As part of our on-going Quality Assurance Program, we review each death which occurs in the hospital on a case-by-case basis to identify opportunities to improve patient care and to provide a positive outcome from the health care encounter whenever possible.

With regard to the 36 Medicare deaths, we would like to offer the following observations:

42% of these patients were in the final stages of a terminal illness at the time of admission.

39% were over the age of 80.

36% were patients in which the family or patient requested that heroic medical efforts not be initiated.

14% of the patients or their families reported that medical care had been postponed or delayed until the condition became critical.

14% of the patients were admitted from nursing homes.

Finally, we would like to point out that the disease classification system used by Medicare categorizes patients based upon the reason for admission, and not the patient's most critical condition or the cause of death. For example, a terminal cancer patient may be admitted for treatment of a urinary tract infection and die during the

hospitalization. The Medicare data would seem to indicate that the patient dies of renal disease rather than the actual cause of death.

While we welcome Medicare's continuing efforts to define quality patient care, we would like to urge extreme caution in the interpretation of the Medicare mortality data.

The Medical Staff and Administration of Harris Methodist Northwest will continue to review patient care for quality and appropriateness because such review is part of our ongoing commitment to maintain and improve healthcare. Again, thank you for the opportunity to respond.

Sincerely,

N. R. Belanger,
Administrator

Gary L. Rose, M.D.
Chief of Staff

Harris Methodist
Stephenville

October 22, 1987

Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the 1986 mortality statistics for our hospital.

Harris Methodist Stephenville is a rural acute care facility located in the community of Stephenville, Texas. We are a full service health care facility caring for patients with many different medical and surgical problems. In addition to acute care, we provide special services such as Obstetrics, General Surgery, Ophthalmology, Pediatrics, Anesthesiology, and Dialysis. In response to the ever changing needs of the community we serve, we recently completed a renovation and expansion program. We added state-of-the-art Emergency and Intensive Care/Coronary Care services.

Our hospital strives to deliver superior care to our patients. We have an ongoing program of Quality Assurance. Our hospital-wide QA Committee monitors the quality of care given in each department. Our Medical Executive/Quality Review Committee monitors the quality of medical care. Peer review activities are an integral part of the function of the committee. This committee performs intensive review of the medical records of every death case in our facility. Our monitoring system provides us with a continuous feedback mechanism to meet and exceed quality care standards.

Harris Methodist Stephenville has been accredited with the Joint Commission on Accreditation of Hospitals since 1967, continuously meeting their high standards of quality.

Our Directors of Medical Records and Quality Assurance departments have reviewed the data in your mortality report and have validated that, with minor exceptions, the information is correct.

Our Medical Executive/Quality Review Committee has performed a more intensive review in the area of Gastrointestinal Disease (our only catagory that exceeds the norm of predicted mortality). The following summarizes the findings in this catagory:

A member of
Harris Methodist Health System

411 N. Belknap/Stephenville, Texas 76401/817-965-3115

The 14% mortality rate given in Gastrointestinal Disease represents 13 cases of death out of a total of 93 cases treated.

- Ages of these 13 deceased patients ranged from 65-96 years.
  Only 2 cases were under 70 years of age.
  Nine (9) of these cases were over the age of 80 years.

- Four (4) of the 13 cases were admitted from Nursing Homes.
  Two (2) patients were transferred in from other hospitals in extremely critical condition.
  One of these cases patient/family requested no cardio-pulmonary resuscitation.

- Three (3) of the 13 cases expired following hospital discharge.
  One of these cases expired due to causes unrelated to the reason for earlier hospitalization.
  Two (2) of the cases were terminal upon discharge and patient/family requested no further treatment.

- In 2 other cases not previously mentioned, the patient/family requested no cardio-pulmonary resuscitation.

The Governing Board, Administration, and Medical Staff are proud of our Quality Assurance program and believe that it is part of the commitment that we have with our community to deliver quality health care. We are continually alert to areas that we can find for improvement. Your data provides us with another tool in which we can focus our efforts.

We appreciate the effort involved in compiling these statistics and thank you again for the opportunity to respond to your report.

Sincerely,

Ray Reynolds, Administrator
Harris Methodist Stephenville

sfs/

Doctors Hospital

3205 West Davis
Conroe, Texas 77304
Tel (409) 756-0631

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Please include the following comments when publishing the HCFA Mortality Data.

> "Doctors Hospital does not believe that the HCFA mortality data indicates the quality of a hospital. First, the death list does not comment on the quality of care and dignity patients received before they expired. Second, hospitals have historically had a role as a place to die and death was the expected outcome of many of these patients. Third, the HCFA mortality data assigns deaths to Doctors Hospital of patients who died in other hospitals, nursing homes, or homes: places where we have no influence or control. In summary, HCFA mortality data may have some value for scholarly researchers but the data has no value for consumers evaluating the quality of hospital services in their community."

Please call me if you have any questions these comments.

Sincerely,

Michael D. Murphy

Michael D. Murphy
Assistant Administrator

HCA Medical Center of Plano

CERTIFIED MAIL
RETURN RECEIPT REQUESTED

October 23, 1987

Medicare Provider #450651

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Doctor Roper:

HCA Medical Center of Plano is a 233-bed acute care facility. We are a full service medical center offering care in such specialty areas as open heart surgery, cancer care, kidney disease and major orthopedic services, as well as general medicine and surgery. A significant number of our patients are admitted with major medical and surgical illnesses. In addition, our emergency department's trauma center is one of the busiest in the Dallas area.

The Medical Staff conducts a review of each death at this hospital. This mortality review is an ongoing process in our quality assurance program. As such, it is an integral part of the overall monitoring of the medical care provided at HCA Medical Center of Plano. It is always helpful for us to receive more information for our review process. Because this is the first time we have had post-hospital discharge mortality data, we have taken the opportunity to add this information to our review process. It would have been even more helpful to receive data covering several years in order to study the significance of year-to-year variations. Without this information it is difficult to use this report to the fullest extent in tracking trends.

3901 West 15th Street
(Norman Whitsitt Pkwy West)
Plano, Texas 75075-7799
Tel: (214) 596-6800
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Even though the hospital-specific mortality data reported by the Health Care Financing Administration fell well within the predicted ranges for our hospital, representatives from the Medical Staff and hospital administration, along with the directors of continuity of care and medical records, all carefully reviewed these cases a second time. Our analysis revealed no patterns or trends in these cases for the reporting period.

Our hospital's quality assurance monitoring system provides us with a continuous feedback mechanism. This system ensures that HCA Medical Center of Plano patients receive health care which meets the highest standards for quality.

Sincerely,

Allyn R. Harris

Allyn R. Harris
Administrator

ARH/bb

[redacted]

MIDWAY PARK MEDICAL CENTER

October 23, 1987

William L. Roper, M. D.
Administrator
Healthcare Financing Administration
Washington, D.C. 20201

Midway Park Medical Center
Medicare Provider #450715

Dear Dr. Roper:

Midway Park Medical Center is a 90-bed acute care community hospital. We provide comprehensive care with our cardiovascular lab for heart patients, an Intensive Care Unit, a Level III emergency room, medical, surgical, obstetric and day surgery units, in addition to being a Hospice care provider for dying patients. We are accredited by the Joint Commission on Accreditation of Hospitals and the Texas Department of Public Health.

The medical staff of Midway Park reviews the medical records of each patient that dies in this hospital. The medical staff also reviews for the appropriateness of care given on an ongoing basis. However, when we received your report, we formed a task force to analyze your findings. The team included the President of the Medical Staff, the physician Chairman of the Patient Care Committee and the Directors of Nursing, Medical Records and Quality Assurance. The following summarizes our findings:

We were able to validate that most of your data is accurate. We admitted Medicare patients 883 times last year. Of those admissions, 83 patients died here. Of note: Of those patients that died, three-fourths presented as emergency patients in grave health. The severity of their illness was on average 2.5 comorbid diseases. In addition, half the patients that died, the families requested that no further heroics be done for the patient, and they were made "do not resuscitate" patients.

As previously stated by yourself, mortality rates, on their own, are not a complete measure of the quality of care at an individual hospital. Midway Park will continue review on the overall quality of care that is provided at this hospital, as we have done in the past.

Thank you for the opportunity to present our response.

Sincerely,

Anthony Jung, M. D.
President, Medical Staff

Jim White,
Administrator

2600 West Pleasant Run Road
Lancaster, Texas 75146-0720
Telephone (214) 223-9600

An Affiliate of
HEALTHTRUST
INC. The Hospital Company

HCA North Hills Medical Center

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington D.C. 20201

Dear Dr. Roper,

We appreciate the opportunity to provide input on the mortality statistics for the period of January 1 thru December 31, 1986, prior to public disclosure.

HCA North Hills Medical Center is a 160 bed acute care facility, whose patient mix includes a variety of medical and surgical illnesses. HCA North Hills Medical Center is a full service hospital offering obstetrics, orthopedics, pulmonology, intensive care, and general medical and surgical inpatient and outpatient services.

A multidisiplinary medical team of physicians in conjunction with the Director of Quality Assurance conducts an extensive review of every patient that expires at our facility regarding medical case management and overall continuity of care administered. The mortality review process is ongoing and a vital component of our quality assurance and peer review programs. Our quality review program is developed to access and monitor all aspects of care for all patients and is ongoing, not just when the mortality data is released. With few exceptions, the statistical information provided by the HCFA mortality study was reviewed and deemed accurate.

Our findings regarding the diagnostic category, Pulmonary Disease, are stated as follows. The range of predicted mortality for our hospital and this category was 13% to 31% and ours was 33%. It should be noted that:

4401 Booth Calloway Road
North Richland Hills, Texas 76180
Telephone (817) 284-1431
A Subsidary of HCA The Healthcare Company

A. The average age of these patients was 80 years.

B. All of the thirty cases had co-morbidities (ie., complications) upon admission.

C. Six percent of these patients/families requested "no code" (ie., no life saving measures) during their stay due to an existing co-morbidity (ie., complications).

D. This represents one of the major service centers of our facility.

Thank you for the opportunity to present this information.

Sincerely,

William M. Gracey
Administrator

WMG/le

HCA Northeast Community Hospital

October 21, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

The physicians and staff at Northeast Community Hospital wish to thank the Department of Health and Human Services for providing the Medicare Mortality Data for 1986. Such information is an invaluable tool in the measurement of "quality"....a tool which most providers would be unable to develop on their own. Northeast Community looks forward to the continuation and refinement of this important information system.

Northeast Community Hospital continually monitors all aspects of patient care services to assure that our high standards for quality are met. Quality assurance programs extend throughout operations to include nursing, ancillary services, technical and administrative support, plus physician care and continuing medical education. Northeast also convenes a Mortality Review Committee which thoroughly investigates every death. This process serves as the final grading

1301 Airport Freeway
Bedford, Texas 76021
Telephone (817) 282-9211
A subsidiary of HCA The Healthcare Company

mechanism on quality care. From it, we are able to upgrade our services and refine quality assurance programs on an ongoing basis. Results from the Medicare Mortality Data confirm the belief that our investment in these programs indeed produce quality results for our patients.

Measured mortality rates across all diagnostic categories found Northeast Community Hospital within predicted ranges in every case. We are extremely proud of these results. Yet we would like to point out that no two hospitals can legitimately be compared for quality based solely on this data. We believe it is extremely important for the public to understand that predicted mortality rates are specific to each individual hospital, based on services available from that specific hospital. For a hospital to fall within its predicted mortality ranges simply means that mortality rates at that hospital do not indicate any problems in quality care, based on the level of services available from that hospital.

Northeast Community intends to use these results each year to help in monitoring our quality assurance programs. From these, we can help determine areas where there may be room for improvement. We can also find confirmation that improvements made in our services

indeed result in improved patient care.

There are many other measures of quality which the public should consider in selecting a hospital, such as whether or not the hospital is accredited by the Joint Commission on Accreditation of Hospitals and/or the American Osteopathic Association; whether or not its emergency room is staffed 24 hours a day with experienced emergency physicians; the qualifications required for its nurses; employee attitudes; and what services it offers. Our 200-bed hospital is accredited by both the Joint Commission and the American Osteopathic Association (AOA). We are also a certified teaching hospital for general internships, family practice medicine, orthopedic surgery, and anesthesiology residencies. We have a 12-bed intensive/critical care unit; offer general, ENT, orthopedic and plastic surgery; cardiology; pediatrics; oncology; neurology; pulmonary; OB/Gyn and labor delivery services; 24-hour emergency room services provided by emergency medicine physicians. We also have a new Hospice and in-patient rehabilitative care unit.

The data for our hospital show that the current standard of care at Northeast Community is actually the standard which we strive to maintain. We are proud that the data indicate no significant problems. We will, however, use

it as a baseline for further quality improvements. Our physicians and staff join me in sincere appreciation for the opportunity to include these comments with the published data.

Sincerely,

Robert M. Martin
Administrator
and Chief Executive Officer

James W. Linton, D.O.
Chief of Staff

RMM/JWL/jaf

HCA Rio Grande Regional Hospital

October 26, 1987

William L. Roper, M.D.
Administrator
HCFA
Washington, D.C. 20201

Dear Dr. Roper:

HCA-Rio Grande Regional Hospital is a 220-bed acute care facility. As a full service acute care facility, we offer care in specialty areas such as open heart surgery, non-invasive cardiac procedures (cardiac catheterization, coronary artery angioplasty), orthopedic services, renal dialysis, as well as general surgery and medicine. Therefore, the type of patients treated at our facility include many with major surgical and medical illnesses.

On an on-going basis, the appropriate clinical department reviews every mortality in our facility regarding appropriateness of care. This review process provides the hospital with an effective mechanism in an effort to continue to meet and exceed quality care standards.

The hospital specific mortality data as reported by HCFA has been reviewed by the hospital Administrators, Chief of Staff, Utilization Review Department, as well as the Medical Records Director. We are pleased to report that the categories listed fall within the hospital specific predicted range for our facility.

Thank you for the opportunity of including our comments with the publication of this data.

Sincerely,

William A. Burns
Administrator

WAB:mr

101 East Ridge Road
McAllen, Texas 78503
Telephone (512) 631-9111
A subsidiary of HCA The Healthcare Company

HCA South Arlington Medical Center

October 28, 1987

William L. Roper, M.D.
Health Care Financing Administration
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for Medicare patients for 1986. Since receiving the report dated September 21, 1987, our facility has had an opportunity to review the data.

The mortality data for South Arlington Medical Center appears to be accurate. Our actual mortality rates fall within the predicted range set for our hospital. It is to be noted that the range of predicted mortality rates is different for every hospital. Data between hospitals should not be compared and interpreted as a difference in quality of care.

Our hospital medical staff committees monitor every death in our hospital on an ongoing basis. These deaths are reviewed to ensure the patients received appropriate and quality care. We believe the results of these reviews provide us with the information necessary to ensure that our hospital meets and exceeds quality care standards.

Sincerely,

Michael S. Spurlock
Administrator, CEO

3301 Matlock Road
Arlington, Texas 76015
Telephone (817) 465-3241

HCA Woodland Heights Medical Center

October 23, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the data on Woodland Heights Medical Center's hospital mortality rates for 1986. The data released by Health Care Financing Administration (HCFA) was carefully reviewed by our hospital and medical staff. Woodland Heights is pleased with the accuracy of our statistics which are below the median of the ranges determined by HCFA for our facility.

We would like to comment that because the HCFA data is not all-inclusive, it is our hope the public will evaluate the information with the following facts in mind:

- The reported deaths are for Medicare patients only, and therefore do not show the mortality rate of our hospital based on all admissions.
- The "Range of Predicted Mortality Rates" is hospital specific using such variables as age, sex and severity of illness. Therefore, rates between hospitals cannot be compared.
- 54% of the deaths reported are of patients 80 years of age or older.
- 18% of the deaths occurred after the patients were discharged from Woodland Heights.
- The report reflects Medicare deaths that occurred within 30 days of an admission during 1986.

500 Gaslight Blvd
Lufkin, Texas 75901
Telephone (409) 634-8311

Woodland Heights Medical Center is a 117-bed acute care facility committed to providing quality health care. All mortality cases are reviewed for quality and appropriateness of care given to our patients, and a plan of action would be immediately implemented if any deviation from our standard was discovered.

Once again, thank you for allowing Woodland Heights to respond.

Sincerely,

M. L. Lagarde, III
Administrator

MLL/bc

HCA Wysong Medical Center

October 22nd, 1987

TO: Health Care Financing Administrations
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

FROM: Wysong Medical Center
Medicare Provider # 450394

SUBJECT: HCFA Mortality Data

The data used by HCFA indicate that a total of 14 Medicare patients whose last admission to Wysong in 1986 was under the diagnostic category of "Sepsis". Our own records indicate that 15 Medicare admissions under the principal diagnosis of "Sepsis" occured in 1986.

The HCFA data also indicate that a total of 10 Medicare patients admitted under the principal diagnosis of "Sepsis" died within 30 days of admission. Of these 7 died while still a patient of the hospital, while 3 died after discharge.

In the diagnostic category of "Sepsis", the hospital's actual mortality rate falls outside of the range of predicted mortality rate. After correcting the errors in the total number of Medicare admissions the actual mortality rate falls to 66.6%.

Sincerely,

Tod Lambert

Tod Lambert
Administrator

130 S Central Expressway
McKinney, Texas 75069
Telephone (214) 542-9382
Metro 235-6650
A subsidiary of HCA The Healthcare Company

Hemphill County Hospital

1020 S. 4th
CANADIAN, TEXAS 79014

Administrator
Deanne Miller
Telephone (806) 323-6422

Board of Directors
Blossom Newell, President
Stuart Anderson, V. PR.
Jane Bartlett
Eugene Thompson
Sam Scroggins

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Medicare Provider Number: 450578

The following information for Hemphill County Hospital is to be attached to the Hospital's Mortality Review for the period of January 1, 1986 through December 30, 1986 prior to public disclosure.

Hemphill County Hospital is a 26 bed rural hospital whose case mix includes patients of all illnesses. We are a full service Community Hospital offering care in areas of obstetricts, surgery, allergies, and general medicine with the one on one patient care which is usually only available in a rural hospital.

The Medical Staff at Hemphill County Hospital conducts an intensive review of the medical records of every patient who expires at this facility regarding medical management and overall care. Mortality review is an ongoing process of the Quality Assurance Program and peer review activities are an integral part of the monitoring of the healthcare at this hospital.

The hospital's specific mortality data reported by HCFA has been carefully reviewed by the Hospital Administrator, Physician Chairman of the Utilization Review Committee, Director of Utilization Review and Quality Assurance, and the Director of Medical Records. Our percentage of deaths is less than the predicted mortality rate for this hospital by HFCA.

During review it was noted that these were old age related deaths of debilitating illnesses and suffering from longstanding pre-existing conditions of which family members requested no heroic measures to be performed in saving the patient's life. This data alone does not measure the quality of care given at our hospital.

Thank you for the opportunity to present this response.

Sincerely,

Deanne Miller

Deanne Miller
Administrator

HENDRICK MEDICAL CENTER - MEDICARE PROVIDER NUMBER: 450229

October 22, 1987

William L. Roper, M.D.
Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
Post Office Box 26676
Baltimore, Maryland 21201

Dear Dr. Roper:

This letter is to comment, for the record, on the "selected mortality information" which is planned for public release in December. It responds to your letter dated September 21, 1987.

We have found numerous, serious errors in the data which was sent to us for review prior to the release. Substantial portions of the information are so terribly flawed that the credibility of the entire Health Care Financing Administration release relating to Hendrick Medical Center data is severely compromised. We enumerated specifically those discrepancies to your department in October, 1987, in an appeal to you to either (1) correct the gross misinformation, or (2) delete its publication entirely.

Hendrick Medical Center, a 64-year-old community not-for-profit general hospital, has historically maintained a structured, ongoing, effective Quality Assurance program for medical care rendered to all patients. This tradition began well before the establishment of Medicare.

Our data systems for facilitating meaningful, effective medical care quality assurance not only pre-date Medicare, but they are separate, independent, and untainted by financial control-driven systems. Medicare systems are government cost containment systems, with primary focus on financial controls. Hendrick Medical Center patient care evaluation systems, on the other hand, are medical quality assurance systems, with primary focus on standards of medical care.

The physicians and other health professionals here conduct a thorough review of the quality of medical care rendered to all patients under our care. We do this whether they are Medicare or not, and the effectiveness of these reviews is monitored regularly. The Joint Commission on Accreditation of Healthcare Organizations has surveyed us on this, against some very high standards of care, then bestowed on us its highest commendations for our hospital's Quality Assurance program and the excellent peer review process that is performed here.

Sincerely,

Michael C. Waters
President

Jack D. Ramsey, M.D.
Chief of the Medical Staff

MCW/kb



HERMANN

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Hermann Hospital appreciates the opportunity to provide further information on the 1986 Medicare mortality statistics. We request that these comments be attached to the Hospital Specific Report for Hermann Hospital for public disclosure.

Hermann's Medicare mortality rate for 1986 fell within the range of predicted mortality rates in the overall category and in all of the specific diagnostic categories reviewed. It is important to note that the complexity of illnesses seen at the hospital and the hospital's higher mortality rate directly correlate with the mission of Hermann Hospital. Hermann has a multifaceted mission, composed of teaching and research, serving indigent patients through its Charity Care program as outlined in the will of its founder, and treating private patients referred to the hospital from throughout the region. Hermann serves as the only core teaching hospital for The University of Texas Medical School at Hermann (UTMSH), as compared to most other major medical schools, which are affiliated with more than one hospital as the site for core teaching and research.

Hermann serves as a major tertiary referral center for hospitals in the Houston area and southeast Texas, and receives transfer patients who need specialized care. The hospital is one of three Category I rated shock trauma centers in the Houston-Galveston area. Key Hermann programs include the Hermann Life Flight air ambulance service, sophisticated trauma services, and other medical specialty services that Hermann provides as the primary teaching hospital for UTMSH. These include intensive care units, the Texas Kidney Institute, the burn center, cardiology, surgical subspecialties and oncology, as well as general medicine.

Hermann Hospital
Texas Medical Center
6411 Fannin
Houston, Texas 77030-1501
713-797-4011
Affiliated with The University of Texas Medical School at Houston

Because of these services, Hermann admits many patients who are more seriously ill and have a higher than average expected mortality than the patients admitted to community hospitals. The private hospital also treats a significant number of indigent patients through its Charity Care program, who have not received the benefits of good nutrition and routine preventive medical care.

The data reported by HCFA has been carefully reviewed. The diversity of admissions as shown in the mortality data, with cases in each diagnosis area, is consistent with the hospital's teaching and referral function. The hospital had low mortality rates in the categories of orthopedics, urology, renal disease, ophthalmology and cancer.

The majority of the Medicare patients who died were admitted through Hermann's shock trauma center, indicating the seriousness of their illness. The hospital reviewed each patient death in the five categories where the hospital's actual mortality rate was in the high area of the predicted range for that category. Of the 73 cases reviewed by the hospital, 94 percent were admitted through the shock trauma center. In addition, most of the Medicare patients had many chronic problems, as well as the acute problems that brought them to the hospital. Those patients with several comorbidities (other diseases or conditions) have an increased severity of illness and risk of death.

Because of the very serious illness and injuries seen at Hermann, in some cases, death is the expected outcome or considered a significant possibility during that patient's hospitalization or soon after discharge. Case review of five major categories of data showed that 30 percent of the Medicare patients who died had been designated "Do Not Resuscitate" (DNR) by themselves or their families. Patients or families often request no heroic or life support measures for terminally ill patients. This is an important point for the health care consumer to understand fully, to avoid misconceptions that the Medicare patient's death is the result of poor quality care.

Following is a brief summary of the hospital's analysis of the five major areas where the hospital's actual mortality rate was in the high area of the predicted range for that category.

<u>Gastrointestinal Disease, Low-risk</u>
The predicted percentage of deaths in the category was a range of 3 to 10 percent; Hermann's rate was 10 percent.

* Sixteen of 17 Medicare patients who died were admitted through the Emergency Room, and 6 of the patients had massive gastrointestinal bleeding. All had at least one comorbid condition, which included cirrhosis or hepatitis, alcohol abuse, renal disease, cardiovascular disease, cancer and anemia. Twelve of the patients had at least four comorbid conditions.

* Four patients and/or their families had requested "Do Not Resuscitate" (DNR).

Heart Disease, Low-risk
The predicted percentage of deaths in the category was a range of 2 to 9 percent; Hermann's rate was 9 percent.

* Of 16 Medicare patients who died, five were transported to Hermann by Life Flight, and a total of 14 were admitted through the Emergency Room because of their serious condition. Four patients were admitted after suffering cardiac arrest at home or at another hospital.
* One patient was not a surgical candidate and another had refused pacemaker implantation. Prognosis was stated to be poor at the time of admission.
* One patient identified as dying out of the hospital actually had been discharged nine days before death, after being identified as a non-surgical patient and stabilized on medication, and had been readmitted with a heart attack.
* Eleven of the patients had from 4 to 6 comorbidities, including various cardiac conditions such as previous heart attacks, congestive heart failure and history of disturbance in heart rhythms, pulmonary disease and diabetes.

Sepsis
The predicted percentage of deaths in this category was 15 to 71 percent; Hermann's rate was 70 percent.

* Of 7 Medicare patients who died, 2 were over 90 years old and the remaining 5 were over 70. All were admitted through the Emergency Room, 2 from nursing homes.
* Physical conditions which limited mobility were common in this group, and all the patients were debilitated before admission. All had 2 or more comorbid conditions, including cancer, malnutrition, cardiovascular disease and orthopedic conditions such as joint replacement.
* Four of the 7 patients and/or their families had requested DNR.

Severe Trauma
The predicted percentage of deaths in this category was 3 to 20 percent; Hermann's rate was 19 percent.

* Of 10 Medicare patients who died, all 10 were admitted through the Emergency Room, 3 by Life Flight.
* Four patients were admitted with burns, 4 with neurological injuries such as head injuries, and 2 with multiple injuries. Any size burn in an elderly patient is considered a major injury, and survival rates are quite low.

Two other patients with burns were transferred from other hospitals.
* The number of Medicare deaths in this category reflects Hermann's trauma and burn services.
* Five of the patients died within the first 48 hours because of the severity of their injuries.

Metabolic and Electrolyte Disorders
The predicted percentage of deaths in this category was 12 to 35 percent; Hermann's rate was 33 percent.

* Of 23 Medicare patients who died, 21 were admitted through the Emergency Room. Three were transferred from nursing homes.
* Nine patients died within 48 hours of admission because of the severity of their illness. Patients were admitted with dehydration and imbalances relating to pre-existing conditions such as diabetes and cirrhosis. Eleven patients had cancer of one or more sites, and other comorbidities included malnutrition and diabetes.
* Ten patients and/or their families requested DNR.
* Five patients were reported to have died after discharge; 2 actually were readmitted later and died in the hospital. Two other cancer patients were discharged to home or hospice care with death imminent.

In addition, 23 of the deaths were categorized as All Other Conditions. Review of these cases showed that like the other groups, these patients had a large number of comorbid conditions. Seven patients had cancer of one or more sites, 3 patients had End Stage Renal Disease, and 1 patient had Acquired Immune Deficiency Syndrome.

Thank you for the opportunity to provide this information to assist the public in better understanding the Medicare mortality data.

Sincerely,

Jeptha W. Dalston, PhD
Chief Executive Officer



High Plains
Baptist
Hospital

1600 Wallace Blvd.
Amarillo, Texas 79106
(806) 358-3151

T. H. Holloway, Jr.
Administrator

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

ATTENTION: Comments on HSQ-148-GNC

High Plains Baptist Hospital is a 308 bed tertiary care general and rehabilitation hospital. The hospital is a regional health center serving a 25,000 square mile area in the Texas Panhandle, two adjoining States and a population of 400,000. While all centers of excellence are represented, major emphasis include cardiology, ophthalmology, orthopedics, thoracic and general surgery. Nearly 60% of patients are within the standard metropolitan statistical area of 180,000 and 40% of patients are from the rest of the Tri-State service area. With some counties having over 20% elderly, the Medicare patients represent 45% of all patients and is growing.

High Plains Baptist Hospital's philosophy "A Climate of Concern for the Whole Man" expresses the hospital's strong commitment to all aspects of quality health care for all patients.

Quality Assurance is an ongoing program conducted by the medical staff and all hospital departments in order to maintain the highest level of health care. Coordination and integration of the various problems reported by the medical staff and the hospital departmental quality assurance monitors provide the key factors to a comprehensive program for trending problems which might occur in several areas with the same physician or same department. If problems are identified appropriate action is taken by the Quality Assurance Committee. In addition to Quality Assurance activities, the hospital also provides community educational programs with special programs designed for the needs of senior citizens such as a comprehensive gerontology program.

Although our actual mortality rate fell well within the predicted mortality range in all categories except for Cancer, Gastrointestinal Disease, and Acute Heart Disease where we fell below the predicted mortality range. The methodology for categorizing the deaths is of great concern as it leads to a misinterpretation of the data. One case was reported inaccurately as a death outside the hospital but actually occurred during the hospitalization.

Upon review of all cases in the individual categories, the deaths repeatedly were not related to the category to which they were assigned. Deaths appear to be occurring in low risk categories which tends to reflect poor quality health care when in fact the assigned category had no relation to the cause of death. Even in the high risk categories such as pulmonary disease, numerous deaths were due to cancer of the lung rather than the pulmonary problem the patient was treated for during the last hospitalization. The statistics are again misleading in the low risk categories in the deaths which occurred after discharge as all of these patients had serious life threatening medical problems. Again, the methodology does not take into consideration the intensity or severity of illness which could render the calculations erroneous and misleading. A minimum number of admissions for each category should be attained before being included in the model. The study would have been much more pertinent if the cases would have been categorized according to cause of death.

In conclusion, we recommend you provide sixty days for comments allowing us adequate time for analysis of the data and time to prepare an appropriate response. We further recommend, the Peer Review Organization (PRO's) responsibility with regard to mortality information be more clearly defined, and that prior to the release, the hospitals be given the opportunity to review the public statement Health Care Financing Administration (HCFA) intends to accompany the release of data.

We appreciate the opportunity to present our views on the release of hospital mortality information and we ask your careful consideration of our recommendations.

Respectfully,

Daniel J. Schwartz, M.D., Chairman
Quality Assurance Committee

HILL COUNTRY MEMORIAL HOSPITAL
1020 KERRVILLE HIGHWAY • P.O. BOX 835 • FREDERICKSBURG, TEXAS • 78624 • (512)997-4353

HSQB: ACTION
CC: Somsak; Jones; Greif

DIRECT REPLY DUE 11/6

October 1, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

RE: Mortality Information Publication dated September 21, 1987

Dear Dr. Roper:

This recently published mortality data is one of the most assinine and wasteful expenditures of the tax paid dollars I have ever witnessed. Not only is it unnecessary and it reduplicates many other statistical data services, it is also very confusing. This is one of the most biased statistical publications I have ever witnessed. Despite your "sophisticated statistical techniques" this is probably the most worthless statistical data interpretation I have ever witnessed. In addition, I think this is in violation of PRO rules established by your own organization.

Michael C Jones

MICHAEL C. JONES, M.D.

MCJ:sl

Hill Regional Hospital

101 Circle Drive
Hillsboro, Texas 76645
(817) 582-8425

October 21, 1987

William D. Roper, M.D.
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: Hill Regional Hospital
Medicare Provider 45-0192

Dear Dr. Roper:

In reference to the release of the 1986 Medicare mortality information, the following comments are provided by Hill Regional Hospital.

Hill Regional Hospital, a 92 bed acute care facility, is accredited by the Joint Commission on Accreditation of Healthcare Organizations. Areas of specialty include family practice, pediatrics, surgery, internal medicine, obstetrics and gynecology. The facility also operates a twenty-four hour emergency room. The hospital utilizes state of the art technology as well as highly qualified personnel to provide services to patients with a multitude of medical and surgical illnesses.

The Medical Staff at Hill Regional conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an established ongoing process of the Quality Assurance program. These activities are an intergral part of the monitoring of the health care delivery system and are performed to assure that the medical care provided meets and exceeds standards for quality.

It should be noted that in nine of the sixteen diagnostic categories the actual mortality rate is found in the lower range of predicted mortality. The data reflects that our percentage of mortality for all causes is well within the predicted range.

an affiliate of National Healthcare, Inc.

The Medical Staff of Hill Regional Hospital is committed to excellence in patient care and as has been their practice, will continue to review the health care delivered for quality and appropriateness. This monitoring system focuses not on mortality alone, but includes a mechanism to continually improve the care provided to all patients.

Thank you for the opportunity to present this response.

Sincerely,

John Erwin, M.D.
President of Medical Staff

JE/bd

HILLCREST BAPTIST MEDICAL CENTER
3000 Herring ■ P O Box 5100 ■ Waco, Texas 76708 ■ (817) 756-8011

ALTON PEARSON
President

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
6300 Security Blvd. Room 2D2, Meadows East Bldg.
Baltimore, Maryland 21207

Dear Doctor Roper:

The following comments are offered in response to your letter of September 21, 1987, regarding mortality information about Medicare patients.

Hillcrest Baptist Medical Center is a 405 bed acute care medical center which is fully accredited by the Joint Commission on Accreditation of Healthcare Organizations. Hillcrest Baptist Medical Center offers, to Central Texans a multitude of programs and services. These include the Center for Breast Screening, Surgicenter, Ambulatory Care Center, Lithotripter, the Fentress Cancer Center which provides extensive radiation therapy for the treatment of cancer, Oncology Department, a Magnetic Resonance Imaging Center which will open in January 1988, Rehabilitation Center and birthing/women's services. Medicare patients represent thirty six to thirty eight percent of our total admissions.

The Director of Medical Records has reviewed the data and has verified with a few minor exceptions, that the data is correct.

The mortality data for Hillcrest Baptist Medical Center to be reported by HCFA has been carefully reviewed by hospital administrators, President of the Medical Staff, Chairman of the Medical Staff Quality Assurance Committee, Chairman of the Utilization Review Committee, the Executive Committee of the Medical Staff Quality Assurance Committee, the Director and Assistant Director of the Medical Records Department, the Quality Assurance/Utilization Review Coordinator, the Director of Hospice and Home Health, the Risk Manager, and the Director of Planning and Research.

The slogan of Hillcrest Baptist Medical Center is "Here for Life". We believe that means all of life, from birth to death. We at Hillcrest endorse the concepts of quality of life and dignity for all people in their living. We recognize that dying is a natural part of living. While we are totally oriented to cure and treatment, we do not abandon our patients when medicine has no other cure treatment to offer. When cure is no longer a probable option, we offer care to the dying through our Hospice program and our Home

Health program. Our interest in our patients goes beyond their stay at Hillcrest and extends to their homes and communities. We believe it is a great gift to offer terminally ill patients the choice of care setting in their dying. Many of our Hospice patients elect to leave the hospital knowing they are dying and choosing to live out their remaining days in the comfort of their own homes. Of the 95 Hillcrest Baptist Medical Center patients who died post discharge within 30 days after admission, 82 left Hillcrest Baptist Medical Center with a nursing care plan in an alternate facility, home health nursing, and/or the hospice program. The remaining thirteen patients were discharged directly to home. These patient records were carefully reviewed by a team of physicians and each of these patients received appropriate care and treatment available in the home environment from family members. These patients were primarily terminally ill patients who preferred to spend their remaining days in the home.

There are also times when patients with a limited life expectancy remain at home until near the end of their lives and return to the hospital as death approaches. These patients in our Hospice program may require short term in-patient care for symptom management until death. While we mourn their passing, we celebrate our ability to achieve the goal of comfort and death with dignity. During 1986, 17 deaths in the inpatient setting were hospice patients. Other Hillcrest Baptist Medical Center patients who faced terminal illness received benefit of Hospice counseling and preparation within the hospital setting.

It is a challenge in the health care profession to find that balance between aggressive treatment for cure and the honoring of patient and family wishes for death with dignity. Hillcrest believes that comprehensive medical center care includes a continuum of care that spans the celebration of new life and the celebration of completed life.

Each Clinical Department of the Medical Staff at Hillcrest Baptist Medical Center conducts a review of their respective patient deaths within the hospital. A written report addressing appropriateness of care is prepared for each death.

Since Hillcrest Baptist Medical Center is a regional cancer treatment facility the cancer deaths for 1986 were analyzed and were found to be in line with state and national statistics. Deaths for colorectal, urinary bladder,ovarian, and lymphatic cancer were below the national averages. Hillcrest Baptist Medical Center is an approved cancer program by the American College of Surgeons. Hillcrest has the four major components (Cancer Committee, Tumor Board Conference, Patient Care Evaluation, and a Tumor Registry) required by the agency.

The Tumor Registry continuously collects data on every cancer patient that is admitted to this institution. The data is used to analyse treatment modalities and the patient's response to the treatment. Information gleaned from these followup contacts is furnished to the medical staff.

An analysis of the mortality data for Texas and McLennan County for Severe Acute Heart Disease (HS) revealed that Acute Myocardial Infarction as a cause of death was higher in McLennan County than in Texas as a whole. For ages 65-74 the county rate was 753 deaths per 100,000 compared to 387 per 100,000 for the state. Deaths for pulmonary disease e.g. pneumonia in McLennan County was (26 per 100,000) higher than the state rate (21 per 100,000). Hillcrest Baptist Medical Center therefore, could expect to have a greater volume of patients deaths from conditions where the death rate was higher in McLennan County.

Sincerely,

HILLCREST BAPTIST MEDICAL CENTER

Alton Pearson, President

Medicare Provider Number 450101

HOLY CROSS HOSPITAL 2600 East MLK Blvd. Austin, Texas 78702 (512) 477-9811

A member of the Daughters of Charity National Health System

October 22, 1987

William Roper, M.D., Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C.

Dear Dr. Roper:

We have reviewed the data on hospital mortality statistics for January 1, 1986, to December 31, 1986. The director of Medical Records has validated that, with minor exceptions, the data is essentially correct.

Holy Cross Hospital is a 129-bed acute care facility, with special emphasis on the care of the frail elderly and terminally ill cancer patients. Review of patient care is routinely conducted on every patient at Holy Cross Hospital, as part of our Quality Assurance Program.

Please note the following responses to specific items in the mortality statistical report.

I. Medicare deaths attributed to Holy Cross Hospital numbered 57 for the 1986 calendar year.

   Of these 57 patients, 55 (96%) had either terminal illnesses, or more than one lingering and disabling disease.

   Also of these 57 patients, 46 (81%) requested they not be resuscitated.

II. Holy Cross Hospital had 6 patients with a principle diagnosis of sepsis (DRG #416). Five of these patients died.

   All five of the patients who died had underlying terminal illnesses or underlying chronic conditions, and requested that they not be resuscitated.

Patients requesting a "no resuscitation" status receive therapeutic care, and every effort is made to keep the them comfortable. Patients requesting a return home are accommodated if at all possible.

The mortality data reported by HCFA have been reviewed by the president and CEO of Holy Cross Hospital, president of the Medical Staff, and physician chairman of the Quality Assurance Committee.

Sincerely,

Judith P. Smith
President/CEO
Holy Cross Hospital

Laurence Tokaz, M.D.
Vice President
Medical Staff
Holy Cross Hospital

c: Sister Mary Rose McPhee
Regional Executive
DCNHS - West Central



MEMBER HOSPITAL
TEXAS HOSPITAL ASSOCIATION
AMERICAN HOSPITAL ASSOCIATION
TEXAS ASSN. HOSPITAL AUXILIARIES
BLUE CROSS GROUP HOSPITAL SERVICE
APPROVED JOINT COMMISSION ON ACCREDITATION

MEMORIAL HOSPITAL
HOPKINS COUNTY HOSPITAL DISTRICT
P. O. BOX 275 (214) 885-7671
SULPHUR SPRINGS, TEXAS 75482

DONALD R. MAGEE
Administrator

October 21, 1987

Provider # 450236

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on our hospital's mortality rates for Medicare patients treated in our hospital in 1986.

As a result of review of this data by hospital staff and the utilization review committee of the medical staff, the undersigned request that the following comments be included with release of our data:

1. We are pleased to note that overall expected mortality fell within the expected range. A review of two specific categories, cerebrovascular accidents and severe chronic heart disease, which were outside the range, revealed that in many cases the principal diagnosis did not reflect cause of death. This is not unusual but results when the physician assigns the cause of death to one of these two categories when the cause is not otherwise apparent.

2. Hopkins County Memorial Hospital serves a large nursing home population. There are seven nursing homes with 589 beds in our service area. They provide excellent care to their patients that results in their patients being able to remain out of the hospital until the condition that occasions their admission to the hospital is advanced or they have multiple conditions. This results in an expected high mortality rate when hospitalization is necessary.

3. The patients included in our mortality data were extremely elderly. In the two categories where we exceeded the range, the average age was 80 for stroke deaths and 81 for heart disease deaths.

The medical staff, through the utilization review committee, monitors every death on a monthly basis. We believe that this review, plus many other quality assurance efforts, results in any patient admitted to Hopkins County Memorial Hospital obtaining excellent patient care.

Thank you again for the opportunity to explain cold/hard statistics in terms of the reality of our local situation.

Donald R. Magee
Administrator

Don O'Neal, M.D.
Chairman, Utilization Review Committee

Philip White, M.D.
Chief of Staff

Charles Gilreath
Chairman of the Board

bar

Houston County Hospital

P.O. Box 1129
Crockett, Texas 75835
Tel. (409) 544-2002

October 27, 1987

William L. Roper, M.D. Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for the opportunity to review the HCFA mortality data for calender year 1986 and for the opportunity to provide further insight into this report prior to publication.

We at Houston County Hospital support the aim of your Bureau's efforts at informing the public on health care issues and expect that the data in future years will prove more meaningful as criteria are standardized on a year-to-year basis. Our utilization review, quality assurance, and medical staffs continually review all mortality cases, both for the quality of care and appropriateness of treatment in order to ensure that we continue to meet and exceed those quality standards for the care we provide.

In our review of your data and our records, Houston County Hospital had 869 Medicare admissions during 1986 covering for 507 separate patients. During this period we experienced 65 deaths in the hospital resulting in a 7.48% death rate on Medicare admissions. An additional 25 patients died outside the hospital within 30 days following discharge. Of the 90 total deaths reviewed in your data, the average patient age at time of demise was 80 years old and 25 of the patients died within 48 hours of admission. That not withstanding, it is worth noting that our actual mortality rates are well within the predicted range of mortality with only one exception which will be addressed below.

Affiliated with HCA Management Company, Inc.

We also have examined the mortality data for each diagnostic category on a case-by-case basis, but in order to preserve individual patient confidentiality, will review two of the diagnostic categories in general terms only.

The first diagnostic category we wish to address is that of Metabolic/Electrolyte Disturbances, where the mortality rate on the 32 patients reviewed was 41% or 13 patients, an admittedly small sample size. The upper limit on the predicted range is stated to be 36%. Of the 13 patients listed in this category, only one would actually be placed in this category if they were coded for Medicare in 1987 with the changes in coding guidelines now in effect. The other patients would be in different principle diagnostic categories since they had major terminal illnesses such as cancer and chronic conditions previously diagnosed (such as congestive heart failure), but not actively treated during the final admission. With the changes in 1987 coding guidelines, the actual mortality rate in this category would be only 3%.

The second diagnostic category to be addressed is that of Low Risk Heart Disease where 3 patients out of a total of 39 gave us an actual mortality rate of 8%, well within the predicted range of between 1% to 18%. If these charts had been coded in 1987 using current peer review organization criteria, two of the patients would have been placed in the high risk category due to significant comorbidities, such as cancer. Only one of the patients would remain in the low risk category, since there was no past history on the patient. This was a first admission to our facility and there is no record of the patient having seen any doctor previously.

In conclusion, as can be seen above, there have been changes in coding guidelines that would cause changes in some diagnostic categories which might be more reflective of disease processes we address at Houston County Hospital. We will continue to strive to provide the best quality care possible and use this and future data in our utilization and quality care committees to formulate the best quality care for the citizens of Houston County.

Sincerely,

Jonathan F. Godfrey

Jonathan F. Godfrey
Administrator

TX 238.1

HOUSTON NORTHWEST
MEDICAL CENTER

October 26, 1987

William L. Roper, M.D.
Health Standards and Quality Bureau
Mortality Rates Information
6325 Security Blvd.
Baltimore, Maryland 21207

Medicare Provider #450638

Dear Dr. Roper:

Thank you for the opportunity to respond to the data release by HCFA regarding mortality information from all short term acute care hospitals which treated Medicare patients in 1986.

Houston Northwest Medical Center is a 424 bed acute care Hospital. We are a full service medical center offering care in specialty areas of oncology, dialysis, open-heart surgery, as well as general medicine and surgery. We provide care for thousands of patients with major medical and surgical illnesses each year.

The Medical Staff at Houston Northwest Medical Center reviews the medical record of every patient who expires at our Hospital as part of our Quality Assurance Program. However, mortality review is only one part of a comprehensive program of peer review which enables our Medical Staff to effectively monitor the medical management and clinical outcome of patients treated at our facility in order to assure a high quality of care in all areas.

The Hospital specific mortality data reported by HCFA has been carefully reviewed by the Director of Medical Records, the Director of Quality Assurance, the Chief of the Medical Staff, and Administration. Our overall percentage, and percentages within individual categories all fall within the range of predicted mortality rates set by HCFA. This data will provide another source of information for review within our ongoing Quality Assurance Program; however, we are ever aware that results of treatment are not only influenced by the care rendered but by the seriousness of the patient's illness and general health status.

We support this endeavor by HCFA to provide data for review of mortality by the health care sector. This effort is consistant with our goal of assuring high quality of care for all of our patients.

Sincerely,

Lewis Foxhall, M.D.
Chief-of-Staff

J. Barry Shevchuk
Chief Executive Officer

TX 239

JBS/LF:ps

HUGULEY
MEMORIAL
MEDICAL CENTER

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Established in 1977, Huguley Memorial Hospital is a general acute-care community hospital serving the health care needs of North Johnson and South Tarrant Counties.

In addition to a 24-hour physician staffed emergency room, family-centered childbirth, a full range of ancillary services and an adjacent Doctors Office Building, the hospital operates an on-site Health Fitness Center.

The medical staff at Huguley reviews every patient who dies in our facility regarding medical management and appropriateness of care. Mortality review is an ongoing process of our quality assurance program. We believe our monitoring system provides us with continuous feedback in an effort to continue to meet and exceed quality care standards.

The Health Care Financing Administration (HCFA) has recently released mortality data on our hospital that has been validated by Huguley Hospital's Medical Records Department and, with minor exceptions, is accurate.

The hospital mortality data reported by HCFA has been carefully reviewed by the hospital administrator, chief of the medical staff, physician chairman of utiliization review, quality assurance and director of medical records. We are confident that you and any member of the public who requests a copy of our statistical information will be interested in our summary report.

The HCFA statistics show that of 1,465 Medicare admissions 138 patients died within thirty (30) days of their last admission to Huguley in 1986. This mortality data by diagnostic category is hospital-specific and cannot be compared to another hospital.

The summary data shows that the mortality rate at Huguley is within the predicted range in all categories. To ensure optimum quality, those categories with the highest mortality rate were reviewed.

Our mortality for renal (kidney) disease was 67%, and the predicted mortality ranged from 8-75%. This 67% represents four patients. Three of these four patients and/or their families requested a "do not resuscitate". One died of renal failure secondary to cancer, and two deaths were due to other diseases not related to kidney failure.

Our mortality rate for sepsis (blood infection) was 47% representing seven (7) patients. All these patients came from nursing homes, and three had "do not resuscitate" requests by the patient and/or their families. Together this indicates a group of patients that were severely ill and had quality of life that was unacceptable to their families.

Of the nine (9) patients who died of gastrointestinal (digestive) disease, there were "do not resuscitate" requests from patients and/or their families on six (6) of these patients. One high-risk patient with severe chronic heart disease requiring emergency surgery for gallbladder disease died following surgery from a heart attack. One died of multi-organ failure and pneumonia after cholecystitis (gallbladder disease) was diagnosed.

Thank you for the opportunity to present this response. The medical staff at Huguley Memorial Hospital will continue to review all mortality data for quality of care in a constant endeavor to identify opportunities to improve care.

Sincerely,

John D. Koobs
Administrator

pp

Humana Hospital
Corpus Christi

October 21, 1987

Medicare Provider Number 45-0118

William L. Roper, M.D.
Healthcare Financing Administration
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital-Corpus Christi supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professions in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's quality assurance and medical staff have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

We hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

L. A. Hagens

Leroy A. Hagens
Executive Director

Thomas L. Wilder MD

Thomas Wilder, M.D.
Chief of Staff

[illegible] McCullough Avenue
San Antonio, Texas
[illegible]
Telephone [illegible]

Humana Hospital
Metropolitan

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GWC
Post Office Box 26676
Baltimore, Maryland 21201

Dear Doctor Roper:

Thank you for the opportunity to respond to the hospital specific mortality data provided to us last month. Humana Hospital - Metropolitan applauds the Health Care Financing Administration's (HCFA) desire to educate those interested in Medicare quality issues. While the program is still in its developmental stages, the basic concept is a good one that will help to make the public better informed.

Humana Hospital - Metropolitan is a 273-bed acute care facility, whose case mix includes patients with major medical and surgical illnesses. We are a full service hospital offering care in the areas of oncology, open-heart surgery, major orthopedic services, dialysis, as well as general medicine and surgery.

In response to the release of date, the medical staff at Humana Hospital - Metropolitan conducts an intensive review of the medical record of every patient who expires at this facility. Medical management and overall care are looked at in detail. Mortality review is an on-going process of the Quality Assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, as well as complete review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Because such a small segment of the patient population (the elderly) is represented in this study and the numbers are not adjusted for severity of illness or other factors that affect patient outcome, they should be considered in <u>that</u> context. While the statistical data is useful in this format for professional purposes, it is not very useful to the consumer. As a result, consumers should be informed of the limited scope of the data. I might also add that the public should be cautioned about drawing any conclusions about the quality of a particular hospital.

Our hospital's medical records department has reviewed the data and the director has validated that the data is consistent, with a few exceptions. In light of the fact

that some of the deaths occurred outside the hospital, we have been unable to completely validate some of the data. Additionally, the sampling size was not large enough to be of statistical significance. It should be noted that Humana Hospital - Metropolitan fell within the predicted mortality rates. Metropolitan's actual mortality rate was nine percent, while the predicted range was eight to 15 percent.

I sincerely hope that HCFA will continue to refine the collection and reporting of this raw data. Humana Hospital - Metropolitan will continue to cooperate anyway necessary so that we can all come to a better understanding of how this data can be used to improve health care services.

Sincerely,

Earl Denning

Earl Denning
Executive Director

ED:gm

6250 Highway 83 84 at Antilley Road
Abilene, Texas
79606
Telephone 915 695-9900

Humana Hospital
Abilene

October 20, 1987

William L. Roper, M.D.
Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
Post Office Box 26676
Baltimore, Maryland 21201

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital-Abilene supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality. Our medical staff performs quality assurance and utilization review in order to provide the hospital with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (Medicare beneficiaries) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in enhancing our existing quality assurance programs, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics can be helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's Medical Records Department and Medical Staff have reviewed the data. Since approximately sixteen percent of the deaths occured outside the hospitals, we have been unable to completely validate this data. Generally, we have found it to be consistent with some minor exceptions with our hospital's records. Unfortunately, in some of the diagnostic categories, the number of patients is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable and unacceptable "standards".

We hope this information will be helpful in attempting to refine the collection and reporting of raw mortality data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

David M. Collins
Executive Director

Joe Feguson, M.D.
Chief of Medical Staff

DMC:cd

P.O. Box 10000
1604 Rock Prairie Road
College Station, Texas
77840
Telephone 409 764-5100

Humana Hospital
Brazos Valley

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Studies and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

RE: Response to HCFA on Hospital Mortality Rates

Dear Doctor Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital-Brazos Valley supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be

informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's medical records, quality assurance, and utilization management specialists have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

Specifically, we reviewed all categories and found the medical care to be appropriate based on patient condition. We also found that under category "severe acute heart disease" that the following salient points should be made regarding mortality related to these diagnoses. In addition to the questionable statistical relevance of such a small number of cases we found that 100% of the cases were admitted through the Emergency Department; 30% were in acute cardiopulmonary distress on admission; 50% were "Do Not Resuscitate" at patient/family request; and the mean age of the patient was 80 years.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Please note that Humana Hospital Bryan-College Station, 1305 Memorial Drive, Bryan, Texas 77802 relocated to its new replacement facility, Humana Hospital-Brazos Valley, P. O. Box 10000, College Station, Texas 77840 in April, 1987.

Sincerely,

Pat Cornelison
Executive Director

PC:lk

TX 247.2

[illegible] Center Boulevard
[illegible]
[illegible] TX 385 2511

Humana Hospital
Clear Lake

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We are herein submitting the following comments to be released with our hospital's Mortality Data.

HUMANA HOSPITAL-CLEAR LAKE
RESPONSE TO HCFA ON HOSPITAL MORTALITY RATES

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Clear Lake supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that

context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's committees dealing with quality review and assurance functions have reviewed the data. Since some deaths occurred out-side the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with some minor exceptions with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

Specifically, we reviewed all categories and , under the category of severe chronic heart disease, we found the age range of expired patients listed was 72 to 99 with the average age being 80; of these 24 patients, 17 had exceeded the life expectancy age for the United States. Of the 24 patients who expired, 6 (or 25%) expired subsequent to discharge from the hospital. After reviewing the records of the patients in the study, we are satisfied with the appropriateness of care rendered in these cases.

I hope this informaion will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

William J. Gresco
Executive Director

WJG/mb

TX 248.2

Humana Hospital
Medical City Dallas

October 23, 1987

William L. Roper, M.D. Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for 1986. Humana Hospital-Medical City Dallas supports the Health Care Financing Administration's desire to educate everyone interested in Medicare quality issues and this hospital has a long standing commitment to provide the public with quality health education information.

Humana Hospital-Medical City Dallas is a 555-bed regional referral hospital with many advanced programs including cardiology, cardiovascular diagnostics and surgery, cancer diagnostics and treatment, neonatology, neurology, neurosurgery, and urology. With the latest in technology and 66 separate medical specialties represented on our Medical Staff of 860 physicians, Humana Hospital-Medical City Dallas provides care to a wide range of patients--especially those with complex, severe medical problems. Of the mortality cases listed for this hospital, 25% were patients transferred to Medical City from other facilities to receive the sophisticated care this hospital offers and which is not available at less specialized hospitals.

The information provided by the Health Care Financing Administration is helpful to our hospital's on-going quality assurance program. Humana Hospital-Medical City Dallas has a comprehensive quality assurance program involving the hospital's administration, quality review committees of the Medical Staff, Nursing Service, ancillary departments, and our Board of Trustees. These groups regularly and thoroughly review all admissions which result in patient mortality and patient complications, as well as reviewing uncomplicated cases in order to make continuous improvements in the care rendered to our patients.

The mortality data for Medicare patients provided by the Health Care Financing Administration to Humana Hospital-Medical City Dallas shows all of this hospital's mortality rates within the HCFA determined expected ranges. Even so, the data was still carefully and completely reviewed by the hospital's Executive Director and Administrative Staff; members of the Medical Staff, including the President of the Medical Staff; the Director of Nursing Services; Director of Quality Assurance; and Director of

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Medical Records. This group first validated the data and a few minor discrepancies in the HCFA released data are noted on the returned patient list. Secondly, a thorough clinical review and analysis was done on each record identifying statistical information, complications and co-existing conditions, status upon admission and other data.

While the mortality data are important, conclusions regarding overall quality of care provided to patients at Humana Hospital-Medical City Dallas cannot be made from these statistics. These mortality charts are limited only to Medicare patients who, because of their age, severity of illness and co-existing multisystems problems, are not representative of the hospital's overall population. The total number of Medicare admissions to Humana Hospital-Medical City Dallas only represents 13% of all inpatients treated at this hospital during 1986. In addition, the final diagnosis does not always accurately reflect the patient's condition or causes for mortality. Specific illustrative points include the following:

1. Only 217 total mortality records are represented with some categories such as gastrointestinal catastrophes and metabolic and electrolyte disorders having 10 charts or less. Others such as orthopedic disease, severe trauma, urologic disease and renal disease have less than 5 charts in each category.

2. The average age of all patients included in the statistics was 72 years old with 73% (159) being over age 70; 57% (110) being over age 75 and 30% (66) being over age 80. In certain categories such as pulmonary disease, severe chronic heart disease, metabolic and electrolyte disorders, stroke and severe trauma the average age was 79 years old or above.

3. One hundred and sixty-two patients (75%) had significant easily identifiable co-existing conditions which contributed to the outcome but are not in the single final diagnosis. These include but are not limited to congestive heart failure, renal failure, diabetes and gangrene, hypertension and chronic obstructive pulmonary disease.

4. While 42 patients were classified as having cancer, in actuality 81 patients (37%) had significant active cancer as a co-existing and contributing factor in the mortality. Of the 31 pulmonary patients identified, 9 had cancer of the lung while of the 5 sepsis patients, 3 had cancer with immune suppression. Furthermore, of the 3 orthopedic patients, 2 had bone cancers and 5 of the 17 stroke patients also had existing cancer.

5. Due to the age of the population and severity of illness, in 96 patients (44%) mortality was foreseen at the time of admission and 75 patients (35%) died within the first 12 hours after admission.

6. Seventy-two patients (33%) had "Do Not Resuscitate" orders requested either by the patient or family due to the severity of the patient's illness.

The above comments are only part of the total analysis completed and are provided in order to make the statistical data more meaningful and understandable. We recognize that this program is in its early developmental stages and we will continue to support the development of programs and information which will educate the public about prevention of illness and quality of care.

Sincerely yours,

Ira B. Korman, Ph.D.
Executive Director

IBK:dms

8026 Floyd Curl Drive
San Antonio Texas
78229
Telephone 512 692-8110

Humana Hospital
San Antonio

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Resources
Washington, D.C. 20201

Dear Dr. Roper:

The administration of Humana Hospital-San Antonio appreciates the opportunity to comment on the hospital specific mortality data provided to us late last month. Although still in its development stages, the Health Care Financing Administration's desire to educate the public and others interested in Medicare quality issues is a noble goal. This type of quality measurement is clearly the wave of the future.

Information on hospital specific mortality data is helpful to all hospital's ongoing quality assurance programs. It further supports regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance and utilization review programs, as well as complete outside review by organizations such as the Joint Commission on Accreditation of Health Organizations.

The raw numbers provided reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly). Since the numbers are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and serve as only one of numerous indicators of a hospital's quality of services. The statistical data, as provided, is useful to professional evaluation, but is not beneficial to consumer use. Consumers should be warned of the limited scope of these numbers, and be cautioned about drawing conclusions based solely on this data.

We recognize that such data is important to physicians and other medical providers in identifying patient trends and treatment outcomes. Such data provides information which can be useful in treating future patients. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's mortality rates have been reviewed and found within the acceptable range of predicted mortality rates for every diagnostic category. We want to point out, however, that your data in some categories is too small to provide a valid statistical analysis. The predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner that it would be inappropriate to consider them acceptable or unacceptable "standards."

It is our hope that the Health Care Financing Administration will continue to refine the collection and reporting of raw hospital data. Humana Hospital-San Antonio will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Timothy L. Austin
Executive Director

TLA/hrm

FROM: Humana Hospital Southmore
(Hospital)

Pasadena, Texas
(City)

SUBJECT: Hospital Authorization to Release HCFA Mortality Data to AHA, THA, DFWHC, GHHC

As announced in the August 17, 1987 Federal Register, the Health Care Financing Administration (HCFA) plans to release in December, 1987, information about hospitals' overall post-admission mortality rates and specific mortality rates for specific medical conditions. Future informational releases are planned by HCFA as part of its continued review of the quality of care provided by hospitals participating in the Medicare program.

The release of hospital mortality statistics or other quality of care data and measurements raises questions for individual hospitals and the hospital industry generally. In order to assist the hospital industry in interpreting such data releases, and responding to the public and press, the Humana Hospital Southmore Hospital is authorizing the release of statistical data (either specific to this hospital or aggregrate data issued by HCFA) to the American Hospital Association (AHA), the Texas Hospital Association (THA), the Dallas/Ft. Worth Hospital Council (DFWHC), and the Greater Houston Hospital Council (GHHC).

This release also allows AHA to provide any studies or interpretation of such data or information releases to the THA, DFWHC and GHHC.

Signed [signature]

Position Executive Director

Date October 16, 1987

Humana Hospital
Southmore

October 23, 1987

Health Care Financing Administration
Department of Health and Human Services
Attention: H5Q-148-GNC
P.O. Box 26676
Baltimore, Maryland 21201

RE: Hosptial Mortality Rates

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital-Southmore supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortiality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's medical records and quality assurance has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Nadine Cook
Executive Director

NC:cw

8109 Fredericksburg Road
San Antonio Texas
78229
Telephone 512 699-8000

Humana Women's Hospital
South Texas

October 26, 1987

William L. Roper, M.D.
Administrator, Health Care
Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P.O. Box 26676
Baltimore, Maryland 21201

Medicare Provider No. 45-0725

Dear Dr. Roper:

We appreciate the opportunity to comment on the hospital-specific mortality data provided to us late last month. We at Humana Women's Hospital - South Texas believe in the importance of keeping the public informed about health care quality issues.

While no deaths are recorded for Humana Women's Hospital - South Texas, we are committed to continuing or rigorous ongoing quality assurance activities, which include internal and external review of the care provided. We owe no less to those who depend on us for their health care.

Commenting for healthcare providers in general, we wish to offer the following caveat: the raw numbers provided in the mortality reports do not reflect the context in which the care was provided. One needs to ask questions such as "What percentage of these deaths reflect cases where patients first sought medical care at a terminal stage of illness?" or "Has a particular institution with high mortality demonstrated an expertise in dealing with non-curable diseases?"

While the raw data provided by the Health Care Financing Administration (HCFA) is useful to professional health care evaluators, such as those independent organizations contracted by HCFA to monitor Medicare providers, it is of limited use for consumers and, if interpreted incorrectly, could tragically dissuade someone from seeking care at an institution that is best suited to treat them.

It would be valuable, however, for consumers to know that these statistics are only a portion of the many others that go into the extensive quality control programs currently in place at Humana Women's Hospital and hospitals across the country.

We believe that the American people are due information regarding health care quality. We feel it is our responsibility, in fact, to continue to help our health agencies refine the collection and reporting process so that an important objective shared by consumers and providers alike - quality of care data that is meaningful to all - can be achieved in the near future.

Sincerely,

Thomas E. Casaday

Thomas E. Casaday
Executive Director

TEC/bt

TX 252.1

IRVING COMMUNITY HOSPITAL

1901 N. MacArthur Blvd. • Irving, Texas 75061 • (214) 579-8100

October 22, 1987

William L. Roper, M.D.
HCFA Administrator
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Irving Community Hospital appreciates the opportunity to review the HCFA mortality data for the 1986 calendar year.

Irving Community Hospital's mortality rates did not exceed the HCFA expected ranges in any category for our facility. Our review team has examined the data carefully. The review team included members of the medical staff, administration, medical records, nursing, marketing and quality assurance departments and offers the following observations.

Irving Community Hospital is a 288 bed general acute care hospital with a full range of services. Total Medicare discharges for 1986 were 2616 patients representing 28 percent of the total patient population; only 1392 of our Medicare discharges were included in the HCFA data representing 53 percent of the Medicare population in 1986.

Our statistics closely parallel HCFA's findings; however, we were unable to verify one death and found two of the reported deaths were patients in a category not included in this study.

ICH agrees that while the data are basically accurate as far as numbers of cases are concerned, the public should not use the data as a comparison measure of quality of care between healthcare providers since each facility's range of mortality has been determined by HCFA using a statistical model. Because this model has not been made public, it is impossible for our facility to verify its expected mortality range.

A second concern is that the data is misleading since it includes all deaths, either in the hospital or after discharge, that occurred within a 30 day period following admission. The data do not discount patients who died after discharge and whose death was unrelated to the diagnosis of the last admission. In twenty five percent of the cases of patients who died following discharge from Irving Community Hospital, the diagnosis listed on the death certificate was not related to the diagnosis of the last admission.

The Medical Staff of Irving Community Hospital has in the past and will continue in the future to review each patient death on an individual basis for quality and appropriateness of care rendered. Data are routinely collected on all discharged patients and reviewed by the appropriate medical staff department. Our on-going systematic process of quality assurance was commended by the Joint Commission on Accreditation of Hospitals in February 1987 when they awarded the hospital accreditation for three years.

Sincerely,

Michael O'Keefe, FACHE
Chief Executive Officer
IRVING COMMUNITY HOSPITAL

TARRANT COUNTY HOSPITAL DISTRICT
JOHN PETER SMITH HOSPITAL

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 25584
Baltimore, Maryland 21207

Medicare Provider Number: 450039

Dear Dr. Roper:

The Tarrant County Hospital District, which operates John Peter Smith Hospital, is grateful for the opportunity to comment on mortality information regarding Medicare patients treated in 1986.

John Peter Smith Hospital is a 375 bed public, teaching hospital which serves as the major trauma center for Tarrant County. The hospital's primary mission is to provide health care to the medically indigent citizens in our community. As a full service medical facility, the hospital provides care for major medical and surgical illnesses as well as specialty care in oncology, nephrology, psychiatry, orthopedics, and pulmonary diseases.

All mortalities within the hospital are carefully reviewed at the departmental level and become a part of ongoing Quality Assurance activities which monitor the hospital's health care delivery system. The mortality information provided by the Health Care Financing Administration has been carefully reviewed by the hospital's Medical Staff and will be utilized as part of the hospital's continuous evaluation of services provided.

We feel it is important to note that John Peter Smith Hospital has consistently experienced only a two percent overall mortality rate.

During the timeframe covered by these mortality statistics, John Peter Smith Hospital experienced a significant increase in demand for services resulting in a high occupancy rate and a limited number of beds available for inpatient admissions. Therefore, only the more acutely ill patients were admitted to the hospital. In the sepsis category, the sample size is too small to make an accurate assessment. All patients in this category were admitted

1500 South Main Street • Fort Worth, Texas 76104 • (817) 921-3431

with severe generalized infections and died within 48 hours of admission; a clear indication of the critical condition of the patients upon admission.

Thank you for the opportunity to present this information.

Sincerely,

M.T. Philpot
Administrator

Evalea Glanges, M.D.
President, Medical & Dental Staff

jas

TX 257.1

King William
HEALTH CARE CENTER

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: HCFA Mortality Data

Dear Sirs:

The data used by HCFA indicate that a total of 21 Medicare patients admitted to King William Health Care Center died within thirty (30) days of admission. Of these, fifteen (15) died while still a patient of the hospital, while five (5) died after discharge. Our own records also indicate that of the twenty-one (21) Medicare patients who died within thirty (30) days of admission while still an inpatient, one (1) was still alive at the time of discharge. It is impossible to determine the percentage of the five (5) patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

Several factors may account for the high percent of mortality. Such as only one (1) or two (2) patients admitted to specific diagnostic category. Type of services offered at KWHCC.

Unique Services Resulting in Higher than Average Mortality

Eighty (80) is the average age of the KWHCC patient population.
Hospice program operating through KWHCC.
Skilled Nursing Facility operated throughout KWHCC.
Intermediate Care Facility operated through KWHCC.

(Continued)

323 East Johnson at South Alamo / San Antonio, Texas 78204 / 512-222-0171

Results of Preliminary Medicare Record Review

Identification #	Surname	Dx Category	Age	Date of Admission	Date of Discharge
1. This patient is still alive:					
[redacted]		Home	47	12/17/86	12/22/86 - Home
2. High Risk Diagnostic Category and age factor greater than 75 years old:					
[redacted]		Home	95		
		ME	78		
		PN	88		
		SE	97		
3. Low Risk diagnostic category with a contributing cormorbid condition:					
[redacted]		GI	69		

4. The number of patients in the specific diagnostic category versus the number of patients who died does not reflect accurate statistical data:

Category	Cases Relfected	Deaths
CA	1	1
CE	2	1
GI	4	2
ME	1	1
RN	1	1
SE	2	2

* Note: Our comments are to be included at the time the HCFA Mortality Data Review is published.

Sincerely,

Delfina R. Carrizales

Delfina R. Carrizales, ART
Director, Medical Records

KNAPP
Medical Center

1330 EAST SIXTH STREET • P.O. BOX 1110 • WESLACO, TEXAS 78596 • PHONE (512) 968-8567

October 20, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: HCFA Mortality Data
Knapp Medical Center

Dear Dr. Roper:

Knapp Medical Center is a 180 bed JCAH accredited acute care facility located in the center of the lower Rio Grande Valley in Texas. As an integrated part of our ongoing Quality Assurance Program, the Medical Staff at Knapp Medical Center conducts an intensive review of the medical record of every patient who expires at this facility, with regard to the medical management and overall care provided. Such peer review activities are an integral part of the monitoring of the health care delivery system at this hospital. We welcome the opportunity to respond to our hospital's specific mortality data as computated and reported by HCFA. Such data has been carefully reviewed by members of our Quality Assurance Committee and the following summarizes our findings by specific Major Diagnostic Categories:

1. MDC: HM--Severe Chronic Heart Disease, Designated by HCFA as a High Risk Category.

   The predicted percentage of deaths in this category was reported to be 12 to 35%, with our actual rate to be 40%. It should be noted that:

   A. The 40% death rate represents a total of only 20 patients, 17 of whom expired in the hospital and 3 who expired outside this facility. The average age of our patients in this category was 78 years, with 79 years as the median age.
   B. In order to provide our patients with the maximum opportunity for recovery which may, at times, involve services which are not available at our Hospital, the patient can be transferred to other facilities where any such needed services are available. For example, any patient who has been evaluated as a potentially successful candidate for a more invasive cardiac surgical procedure, such as coronary bypass surgery, will be transferred to a facility where these services are available. For those patients whose condition could not benefit from this kind of opportunity, Knapp Medical Center becomes the final care giver for these patients.
   C. More than half of these patients had had two or more admissions in the recent past for acute exacerbations of their chronic heart disease condition. By the time of their last admission to this hospital, their condition had deteriorated to the extent that both the patients and/or families, after consultation with their attending physicians, had expressed their desire that the patients be allowed to

"die with dignity." It is noted that in 80% of all cases reviewed, a "No Code" order was directed by the attending physician, at the request of the patient and/or family. Since Knapp Medical Center has transfer agreements with three major local nursing homes, we also note that 30% of these patients were transferred in from nursing homes.

D. While all cases met admission necessity according to the existing PRO's (professional review organization) admission criteria, it is quite possible that at least 80% of the patients in this category could have been referred to a hospice care facility, after the presenting acute admission problem was addressed. Knapp Medical Center has always been devoted to serving the needs of its patients and by recognizing how important supportive care is to the family during an end-stage illness, our hospital continues to advocate the concept of total family care. Eighty-five percent of the patients in this category resided in the Mercedes-Weslaco-Donna area, which reflects our hospital's reputation as being a community health care center which dedicates itself to compassionate care of its patients and their families.

2. MDC: CA--Cancer, Designated by HCFA as a High Risk Category.

The predicted percentage of deaths in this category was reported to be 10 to 38%, and ours to be 38%. It should be noted that:

A. The 38% death rate represents a total of only 15 patients, 13 of whom expired in the hospital and 2 who died outside this facility. The average age of our patients in this category was 75 years, with 73 years as the median age.

B. At least 67% of these patients had been previously diagnosed with cancer and/or metastasis and were admitted to the Hospital for terminal care, which consisted of control of pain and relief of discomfort associated with the final stages of the diagnosis. All of these patients and/or families had expressed their desire that the patients also be allowed to "die naturally," and a "No Code" order was subsequently directed by the attending physician, at the request of the patient and/or family.

C. With no past history or admissions for any cancer related symptoms, approximately 33% of the patients in this category were diagnosed with cancer during their last admission to our Hospital. The cancer was found to be so extensive that almost all of these patients and/or families expressed their desire that the patients be allowed to "die naturally" also. Subsequently, the attending physician directed a "No Code" order, at the request of the patient and/or family.

3. MDC: HS--Severe Acute Heart Disease, Designated by HCFA as a High Risk Category.

The predicted percentage of deaths in this category was reported to be 23 to 60%, and ours to be 58%. It should be noted that:

A. The 58% death rate represents a total of only 15 patients, 13 of whom expired in the hospital and 2 who expired outside this facility. An error in HCFA's data is recognized as one patient having expired at another health care facility but was tabulated in Knapp Medical Center's mortality rate. As a result, our corrected actual mortality rate would be 54%. The average age of our patients in this category was 78 years, with 82 years as the median age.

B. Thirty-six percent of the patients in this category arrived in the emergency room with a diagnosis of an acute myocardial infarction, and cardiopulmonary resuscitation was immediately initiated with subsequent admission to our ICCU. The average length of stay for these patients was 5-1/2 hours prior to expiration. Most of these patients were unconscious at their time of arrival in the emergency room and had never regained consciousness.

C. An additional 43% of the patients in this category were admitted to our hospital with a very poor prognosis and were most often unconscious, comatose, or brain-dead. In these cases the patients families, after consultation with their attending physicians, requested that these patients be allowed to die naturally. Most of these patients either deteriorated very rapidly or never regained consciousness.

4. All other Major Diagnostic Categories

We have addressed three areas, as described above, in which our actual death rate was over, or near the upper range of HCFA's predicted mortality rate by individual major diagnostic category for our Hospital. In the remaining 13 major diagnostic categories, our actual death rates, compared to HCFA's predicted death ranges for each individual category, were well within HCFA's predicted ranges.

The Medical Staff of Knapp Medical Center, through its participation in the Hospital's Quality Assurance Program, will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient. The analysis of trends from these reviews is a constant endeavor to assist in identifying opportunities to improve the quality of care provided by our Hospital. Knapp Medical Center reaffirms its commitment to the community it serves to provide the best possible quality care its patients and families require and deserve.

Sincerely,

Robert Vanderveer

Robert W. Vanderveer
Administrator

LAKE CLIFF HOSPITAL
ESTABLISHED 1964

October 6, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Enclosed is a copy of the mortality figures on Medicare beneficiaries as supplied by you. Corrected dates of death have been noted on the list. Also enclosed are Lake Cliff Hospital's comments on the HCFA Mortality Data.

Thank you for this opportunity to respond to this data.

Respectfully,

Judith McDermott
Administrator

JMC/su
enclosures

F COLORADO DALLAS, TEXAS 75203 214-942-8711

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Comments on the HCFA Mortality Data
Lake Cliff Hospital, Dallas, Texas

Data Verification

The data used by HCFA indicate that a total of seven Medicare patients admitted to Lake Cliff Hospital died within 30 days of admission. Of these, all seven died while still a patient of the hospital. Our own records indicate that 127 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at Lake Cliff Hospital is correct. It is impossible to determine the percentage of patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

Reclassification of four cases into diagnosis categories based on actual cause of death (these four cases were considered terminal at the time of admission) and not the diagnosis category being treated during the final admission leaves the hospital's actual mortality rate outside of the range of the predicted mortality rates in only one of the diagnostic categories.

Results of Preliminary Medicare Record Review

Seven patients were admitted with diagnosis of cancer, three of which resulted in death prior to discharge. Death was the expected outcome at time of admission for two of the cases. The third patient had been refused treatment and hospitalization twice at another hospital. Extensive malignant cancer was discovered only after admission.

In both cases of cerebral vascular attack (stroke), death was considered a significant possibility at the time of admission.

Three patients were admitted for gastrointestinal catastrophies. Two resulted in death while still hospitalized. One of the results of alcohol induced irreversible liver failure. The second was 82 years of age with many other complicating problems.

Unique Services Resulting in Higher than Average Mortality

The unique service offered by Lake Cliff Hospital is caring. We do not deny admission to Medicare beneficiaries based on the possibility of death within 30 days of admission or that Medicare may deny a claim filed. Patients are admitted on the basis of need.

Lake Livingston Medical Center

P.O. Box 1257
602 East Church Street
Livingston, Texas 77351
409/327-4381

October 27, 1987

Healthcare Financing Administration
Hospital Mortality Information
Meadows East Bldg, Room 202
6300 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the data compiled by HCFA on hospital mortality rates which will be released to the general public December 1, 1987.

We have reviewed the mortality statistical data provided to us and find that this facility is within HCFA's predicted ranges. As part of our ongoing Quality Assurance program all deaths which occur in our facility are reviewed by a Q.A. physician reviewer utilizing criteria established by the Medicare program to ensure that appropriate care was given. If this reviewer finds a case in which he feels that further review is necessary the case is referred to the entire Quality Assurance Committee for investigation. Currently this method of review provides us with a system that allows us to monitor the quality of care provided to all patients at Lake Livingston Medical Center.

We will continue to monitor this facility utilizing the annually published statistics in order to ensure that we continue to meet appropriate guidelines. Your input and assistance in this area is appreciated.

Sincerely,

Cheryl W. Wood

Cheryl Wood
Director, Medical Records

CW/pp

cc: Jerry Dollison, Administrator

HEALTHSTAR*

LAKELAND
MEDICAL
CENTER

MEDICARE PROVIDER NUMBER - 450389

October 26, 1987

RE: MORTALITY STATISTICS, 1986

Thank you for this opportunity to respond to the release of data on hospital mortality rates for the year 1986.

Lakeland Medical Center is a 103-bed acute care facility, whose patients include those with many major medical and surgical illnesses. The Medical Staff at Lakeland Medical Center conducts a review of every patient who expires at this facility. Mortality review is an ongoing process of the Quality Assurance program and an integral part of monitoring of the healthcare delivery system at this hospital.

The hospital's specific mortality data reported by HCFA has been carefully reviewed by the hospital administrators, the Chief of Staff, and the Executive Committee of the Medical Staff, and selected members of the Utilization Review Committee. The statistics and records have been reviewed and validated by the Director of Medical records and the Director of Nursing Service. With very few exceptions, the statistics were found to be accurate. It should be noted that these statistics refer to Medicare patients only, and do not indicate an overall mortality rate for Lakeland Medical Center. The statistics include all Medicare patients whose last admission was to our hospital, and who died within 30 days of admission. The patient's death was not necessarily during the hospitalization, but may have been at home or in a nursing home.

As is apparent by reviewing the statistics, Lakeland Medical Center's mortality rates for each of the 16 Diagnostic Categories are well within the predicted ranges. Our summary revealed the following regarding two of these categories:

Category EY - Opthalmologic Disease - It should be noted that only one patient fell into this category. Her death, which occured 20 days after her release from the hospital to a nursing home, was unrelated to the problem for which she was hospitalized and was not being treated by any ophthalmologist on our staff.

Category HS - Severe Acute Heart Disease - Seventeen of thirty patients expired within this category. Out of these, one expired 2 weeks after dismissal and six of these expired within 12 hours of admission. Review of these medical records indicated that the remainder of patients had multiple other conditions complicating their heart disease.

2000 S. Palestine • Athens, Texas 75751 • (214) 675-2216

An affiliate of the East Texas Hospital Foundation

As previously stated, a review of all patients who expire in this facility is an ongoing process. This information is utilized in various ways to evaluate and improve the quality of care.

Thank you again for the opportunity to present this response.

Sincerely,

Gene G. McIntyre, Chief Executive Officer
Lakeland Medical Center

GGM/cas

David G. Purifoy, FACHE
Administrator

HCA Lewisville Memorial Hospital

October 1, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir;

Upon review of the 1986 Medicare Mortality information we discovered two apparent discrepancies.

These discrepancies are:

1) Patient ID Number (HIC)-[redacted]

This patient is listed in diagnostic category "SE" with a principle diagnosis number of 0389. Our records show that this patient's principle diagnosis was "Urinary Tract Infection" , Number 599.0; please see attached physician attestation.

2) Patient ID number (HIC)-[redacted]

We have no record that this patient was admitted to this facility.

Please make necessary changes to correct inaccuracies in the data.

Thank you.

Sincerely,

David G. Purifoy, FACHE
Administrator

Provider Number 450669

DGP:mls

500 West Main
Lewisville, Texas 75067
Telephone (214) 420-1000
A Subsidiary of HCA The Healthcare Company

PHYSICIAN ATTESTATION

Patient's Name: [redacted]

Discharge Date: 03/07/86

Principal Diagnosis:	Urinary Tract Infection	599.0
Secondary Diagnoses:	Alzheimer's Disease	331.0
	(3) Citrobacter Diversus Identified	041.8

Principal Procedure:

Date Performed:

Secondary Procedures:

"I certify that the narrative descriptions of the principal and secondary diagnoses and major procedures performed are accurate and complete to the best of my knowledge."

[redacted] 5/21/86

Signature of Attending Physician Date Signed

THIS STATEMENT IS A PERMANENT PART OF THE MEDICAL RECORD. DO NOT REMOVE!

Llano Memorial Hospital

200 West Ollie • Llano, Texas 78643 • (915) 247-5040

PROVIDER #s 450219
45U219

October 13, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Baltimore, Maryland 21207

Dear Dr. Roper,

We find two discrepancies in your mortality data for our hospital. [redacted] is incorrectly included in this data set. The patient is ours. However, she was admitted here and died 01/03/85, not 1986. She should be omitted from this list since she is not part of the 1986 case load. Patient [redacted] is ours and your dates are correct, but on 02/19/86 he transferred to our Swing Bed (SNF) unit and died in Swing Bed. There is probably no need to correct this since it has no effect on any of the calculations.

Please include the following narrative with your publication of this data for our hospital:

Of the 52 Medicare patients who died in Llano Memorial Hospital in 1986, 50 of them (96%) were age 70 or older. The average age was 81. The youngest was 57, the oldest 97. As a group, these beloved members of the Llano Community exceed the national life expectancy averages. This indicates that living in Llano is indeed good for your health and longevity.

Death is a fact of life. That a specified number of deaths occur in a hospital in any given year is also a fact. If even one of these deaths were unwarranted, that becomes a serious issue, and rightfully so. However, given the large geriatric population in Llano County, it is no surprise that deaths occur in Llano Memorial Hospital each year. When facing death, if you are given the proper dignity and compassion that is your due, then death need not be a loathsome thing. For many, death is the ending of this life but the beginning of an eternal life. At Llano Memorial, utmost respect is given to each individual and to the family when the fact of dying is at hand. The documented statistics you have just read bear witness to this truth.

James L Alexander, PhD
Administrator

LGH

Lubbock General Hospital

October 27, 1987

Harvey Brook
Health Standards and Quality Bureau
Room 2-D2 Meadows East Building
6300 Security Boulevard
Baltimore, Maryland 21207

Dear Mr. Brook:

Thank you for the opportunity to provide input on the mortality statistics for Medicare patients admitted to Lubbock General Hospital during 1986.

Through our quality assurance program, the statistical data and specific medical records of patients who expired were reviewed. In all cases, the care rendered was determined to be appropriate.

Lubbock General Hospital is a regional referral center for high risk patients in a wide variety of disease categories. Additionally, 34% of the Hospital's beds are intensive care beds. While the severity of illness for a large percent of the Hospital's patient population is high, the Medicare mortality rate for Lubbock General Hospital remained well within the predicted range.

Through its quality assurance program, the Lubbock General Hospital professional staff conducts an ongoing review of all patient deaths. During its 1987 survey, the Joint Commission on Accreditation of Hospitals commended the Hospital on its quality assurance and peer review processes.

This mortality data provided the occasion to review the care delivered to our patients, and quality of care is our primary concern. Again, thank you for the opportunity to present this response.

Sincerely,

Jim Courtney
Chief Executive Officer

JC/rbp

602 Indiana Avenue PO Box 5980
Lubbock, Texas 79417-5980 806 743-3111
Lubbock County Hospital District

HCFA #8710060305

LUTHERAN GENERAL HOSPITAL
HOSPITAL ID NUMBER: 450685

October 1, 1987

HSQB: ACTION
CC: Somsak; Jones; Greif

DIRECT REPLY DUE 11/3
X REF. 8710030421

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

The list you submitted to us of Medicare patients admitted at Lutheran General Hospital and then died within 30 days of the last admission was reviewed. Several errors were identified and corrections are as follow:

1. [redacted] the name submitted was [redacted] however the patient's name at the time of admission was [redacted] It is possible that the patient was using a card that belonged to another person. All other data correlate.

2. [redacted] patient had a subsequent admission which was on October 1, 1986 and discharged on 10/5/86 which was also the date of death. Diagnosis was bleeding esophageal varices.

3. [redacted] patient's date of death is the same as the date of discharge. Patient died on 12/30/86 at 10:40 p.m.

4. [redacted] patient diagnostic category and principal diagnosis should be PN and 5119.

5. [redacted] patient diagnostic category and principal diagnosis should be IR and 8522.

6. [redacted] patient principal diagnosis should be 78609.

7. Patient ID [redacted] patient had a subsequent admission on 1/2/87, discharged on 1/5/87 which is also the date of death. This case should be included in the 1987 list and not in 1986.

I would like to point out that the principal diagnosis by itself may be misleading. For example 599.0 (urinary tract infection) or 707.0 (decubitus ulcer) may have been the principal diagnosis but in fact the comorbidities, complications and the patient's age (average was 80 years old) were the agents that lead to the patient's death.

701 S. ZARZAMORA ST.
SAN ANTONIO, TEXAS 78285
(512) 434-5252

If you have any questions please call me at (512) 434-5252 or contact Teresa Cardenas-Trowers, Director of Medical Records at the same number.

Sincerely,

Thames F. Jackson, Jr.
Administrator

LUTHERAN GENERAL HOSPITAL

26 October 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Resources
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

Thank you for the opportunity to provide input on the mortality statistics for calendar year 1986 prior to its scheduled public disclosure this December. The Director of Medical Records has validated that, with a few exceptions which were identified to you on a previous letter, the data is accurate. It was noted that we fared consistently within the range of expected mortality in all categories. We would like to have the following comments accompany our mortality statistics:

"Lutheran General Hospital is currently staffed as 106 bed acute care hospital and is located in the heart of the West Side of San Antonio. We serve as the immediate health care facility to a community that is predominantly Spanish speaking, impoverished, chronically ill and elderly. We offer medical, surgical and pediatric services as well as skilled nursing and psychiatric services to the elderly. Medicare beneficiaries account for about 45% of the total admissions. The average age of these Medicare patients is about 80 with an approximate re-admission rate of 50% for all patients. The majority of the Medicare patients are admitted from and discharged to a Nursing Home.

Lutheran General Hospital has developed and maintained a very strong Quality Assurance and Utilization Review Program. Members of the Board of Directors are actively involved in the Quality Assurance Program and provide appropriate oversight. All mortality cases are reviewed by the appropriate Medical Staff Department. This review is done on a monthly basis and results are forwarded to the Medical Staff Executive Committee and Hospital Quality Assurance Committee."

Again, thank you for the opportunity to review the mortality data and clarify any potential discrepancies before it was released publically.

Sincerely,

T.F. Jackson, Jr.
Administrator

TFJJr/ea

701 S. ZARZAMORA ST.
SAN ANTONIO, TEXAS 78285
(512) 434-5252

TX 281.2

FROM: Mainland Center Hospital
(Hospital)

Texas City, Texas
(City)

SUBJECT: Hospital Authorization to Release HCFA Mortality Data to AHA, THA, DFWHC, GHHC

As announced in the August 17, 1987 Federal Register, the Health Care Financing Administration (HCFA) plans to release in December, 1987, information about hospitals' overall post-admission mortality rates and specific mortality rates for specific medical conditions. Future informational releases are planned by HCFA as part of its continued review of the quality of care provided by hospitals participating in the Medicare program.

The release of hospital mortality statistics or other quality of care data and measurements raises questions for individual hospitals and the hospital industry generally. In order to assist the hospital industry in interpreting such data releases, and responding to the public and press, the Mainland Center Hospital is authorizing the release of statistical data (either specific to this hospital or aggregrate data issued by HCFA) to the American Hospital Association (AHA), the Texas Hospital Association (THA), the Dallas/Ft. Worth Hospital Council (DFWHC), and the Greater Houston Hospital Council (GHHC).

This release also allows AHA to provide any studies or interpretation of such data or information releases to the THA, DFWHC and GHHC.

Signed Edward J Smith

Position President / CEO

Date 10-13-87

Harris Methodist
Glen Rose

Marks-English Hospital
Harris Manor

October 23, 1987

Dr. William R. Roper
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper,

Thank you for the opportunity to respond to the Mortality Statistics for 1986.

Our medical staff and quality assurance committees have reviewed your data and found that it compares well with our own data. As part of our on-going commitment to quality patient care, your data provides another tool with which we can focus our efforts in this area.

Harris-Methodist - Glen Rose is a 26 bed primary acute care hospital which strives to deliver the best possible care to all patients. We believe that providing these services and caring for the very sick is our community obligation.

In reviewing our charts with the diagnosis of cancer, an area exceeding the predicted mortality, we found that the 2 patients who expired were very ill at the time of admission and had diseases for which death was the expected outcome. The medical staff reviews the records of every patient who expires in our facility with regard to their medical management and overall care, and such reviews are an integral portion of our overall Quality Assurance Program which monitors many aspects of healthcare at our hospital.

The medical staff and administration of Harris Methodist - Glen Rose will continue to review patient care for quality and appropriateness because such review is part of our on-going commitment to maintain and improve the quality of healthcare.

Again, thank you for the opportunity to respond.

Sincerely,

Gary A. Marks
Hospital Administrator

GAM/sl

A member of
Harris Methodist Health System

P.O. Box 997 / 1307-09 Holden Street / Glen Rose, Texas 76043 / 817-897-2215

Matagorda County Hospital District

MATAGORDA GENERAL HOSPITAL
WAGNER GENERAL HOSPITAL
MATAGORDA HOUSE

1115 AVENUE G
BAY CITY, TEXAS 77414
409/245-6383

October 23, 1987

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hopital mortality rate. Since receiving the report, Matagorda General Hospital has had the opportunity to review the data.

It is to be noted that Matagorda General Hospital is within the norm of the predicted mortality death rate. Of the total 71 reported deaths, twelve (16%) were discharged back to the nursing home or home.

On an ongoing basis, the Medical Staff has always reviewed every mortality that occurred at Matagorda General Hospital for appropriateness of care.

Thank you again for the opportunity to present this response. If you have any further questions or a need for further information, please do not hesitate to contact me.

Sincerely,

Shannon C. Flynn cm

Shannon Flynn, M.C.H.A., District Administrator
Matagorda County Hospital District

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

McCUISTION REGIONAL
MEDICAL CENTER

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Doctor Roper:

We have reviewed the hospital mortality information for McCuistion Regional Medical Center and have noted only minor exceptions to the accuracy of the data as reported.

Though it is important to understand and accept that these data alone are not a measure of the quality of care given by any hospital, we are reassured by the fact that in all categories the hospital's acute mortality rate is within the range of predicted mortality rates as determined by the Health Care Financing Administration. McCuistion has an excellent quality assurance program in which all patient records are reviewed for necessity of admission, appropriateness of care given and other criteria from which quality of care can be determined. This program involves all levels of care givers in a concurrent review process to assure our patients the best health care possible.

We appreciate the opportunity to review and comment on the mortality data before its release to the public.

Sincerely,

Anthony A. Daigle

Anthony A. Daigle
Administrator

AAD/jp

P.O. Box 160, 865 DeShong Drive, Paris, Texas 75460, (214) 737-1111

MEDICAL CENTER HOSPITAL

October 26, 1987

To Whom It May Concern:

Thank you for the opportunity to provide input on the mortality statistics for the period between October 1, 1984, and September 30, 1986.

Medical Center Hospital is a 410-bed acute care hospital--the largest such facility between Dallas and Shreveport. Additionally, we serve as the regional tertiary care and trauma center for a 16-county area. This means that our case mix includes many patients whose medical and surgical illnesses fall into high risk categories. These include severe acute heart disease, pulmonary disease, severe trauma, stroke, cancer and gastrointestinal catastrophies.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: the hospital administrators, the physician chairman and members of the Utilization Review Committee, the Director of Utilization Review, the Director of Quality Assurance, and the Director of Medical Records. The Director of Medical Records has validated that, with minor exceptions, the data is accurate.

In the one high risk category--pulmonary disease--in which our death rate, 33%, was higher than the predicted mortality range of 16 to 31%, we determined the following information:

- One person was listed twice, by different surnames, but with the exact same Medicare Patient Identification Number.
- Seven patients died following dismissal from the hospital, but within 30 days of dismissal. Ranging in age from 65 to 86, these patients had an average age of 78.4. All except one had multiple high risk diagnoses, with no reversible factors. The one had previously been hospitalized for surgery of a fractured hip; she became moribund in the nursing home, was returned to the hospital, where she died.
- Of the remaining 50 cases, 48 had an expected downhill course, despite aggressive treatment, due to co-morbidity factors.
- Thirty-eight of the 50 were placed on "No Code" by request of the family.
- Ages of the remaining 12 patients ranged from 59 to 97, with four persons in their 90's. Average ages were 79 for the men and 83 for the women.

more

P.O. Box 6400 Tyler, Texas 75711 (214) 597-0351
an affiliate of the East Texas Hospital Foundation

Ninety-two percent of these 12 cases fell into two DRG categories: 079, Respiratory Infection Age 69> and/or Complication or Co-Morbidity. and 089, Simple Pneumonia Age 69> and/or Complication or Co-Morbidity. The other 8% fell into two DRG Categories: 078, Pulmonary Embolism; and 087, Pulmonary Edema and Respiratory Failure.

The Medical Staff of Medical Center Hospital, as has been their practice, will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient. Trending analysis from these reviews provides the Medical Staff and hospital staff with assistance in identifying opportunities to improve care.

Because of the growing number--some 2,700 to 3,000--of trauma and emergency cases that our emergency services see a month, we were gratified to see confirmed our low 7% mortatility rate, when the predicted range was 4 to 15%.

Sincerely,

Elmer G. Ellis
President

EGE/pa

Medical Center Hospital

Montgomery County
Hospital District
P.O. Box 1538
Conroe, Texas 77305-1538
409 • 539-1111

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26676
Baltimore, Maryland, 21201

ATTENTION: HSQ 148-GNC
Medicare Provider Number

Dear Dr. Roper:

Thank you for the opportunity to provide input on the mortality statistics for 1986.

The mortality statistical data and the specific medical records of the listed deaths in 1986 were reviewed, with the following findings:

Three of the listed deaths were in 1987 and should not be included in this report.

Category

[redacted] 1/16/87
1/05/87

[redacted] 1/03/87

Our records indicate this patient was admitted 1/02/87 and expired on the date as shown.

Please consider this an appeal for your review and correction.

Yours truly,

John L. Single
Administrator

JLS/mp

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Medical Plaza Hospital, Inc.
1111 Gallagher Road Sherman, Texas 75090 | 214 893-7511

October 23, 1987

Dear HCFA:

Thank you for the opportunity to provide input on the mortality statistics for the period between October 1, 1984 and September 30, 1986.

We find two deaths that occurred within 30 days after admission to our facility occurred in other facilities to which the patients were transferred.

We also find that four patients died at home or elsewhere following discharge from this facility:

1. [redacted] Male, age 82, High Risk, Diagnosis: Heart Disease, Acute Congestive Heart Failure, Pleural Effusion, ASHD, Coronary Atherosclerosis.

2. [redacted] Male, age 47, High Risk, Diagnosis: Heart Disease, Congestive Heart Failure, Status Post Myocardial Infarction, ASHD, Cardiomegaly, Admitted with pre-infarction angina.

3. [redacted]ale, age 45, High Risk, Diagnosis: Severe Acute Heart Disease, Severe Congestive Heart Failure, ASHD, Status Post Myocardial Infarction, Status Post Coronary By-Pass Surgery (3 times), Hypertension.

4. [redacted] Female, age 81, Low Risk, Diagnosis: Profuse Hematuria, Rule out Bladder Carcinoma, History of GU Carcinoma.

It is noted in the review of these Medical Records that three of these patients fell into the High Risk Category.

It should also be noted that Medical Plaza Hospital's ratings fell well within the norms of all categories and were in the lower one-half of each of the statistical ranges.

Our hospital medical staff committees monitor every death in our facility on an on-going basis. We believe that our monitoring system provides us with a continuous feedback mechanism and allows us to continue to meet and exceed quality care standards.

Again, thank you for the opportunity to clarify the mortality data.

Sincerely,

Bill Rowton,
Chief Operating Officer

BR:sca

cc: Mr. Steve Turner
Helen Smith, A.R.T.
Rita McBride, R.R.A.

HCA Medical Plaza Hospital

October 22, 1987

Healthcare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: HCFA Mortality Data Release For Calendar Year 1986
HCA Medical Plaza Hospital
Medicare Provider 45-0672

Dear Dr. William Roper:

Thank you for the opportunity to provide input on the mortality statistics for HCA Medical Plaza Hospital for the calendar year 1986. We would like to request that the following information be included with HCA Medical Plaza Hospital's data.

HCA Medical Plaza Hospital is a 338 bed acute care facility in Fort Worth, Texas. Our Case Mix includes many patients with major medical and surgical illness. We are a full service medical center offering care in specialty areas of Oncology, Open Heart Surgery, major Orthopedic Services, Rehabilitative Medicine, as well as, General Medicine and Surgery. The Hospital is accredited by the JCAH and in accordance with this stature, the medical staff at HCA Medical Plaza Hospital conducts an intensive review of the medical record of every patient who expires at this facility, regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance Program, and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital.

The hospital's specific mortality data reported by HCFA has been reviewed by the Hospital Administration, the President of the Medical Staff, the physician chairman of the Utilization Review Committee, the Director of Utilization Review and Quality Assurance, and the Director of Medical Records.

1612 West Humboldt
Ft. Worth, Texas 76104
Telephone (817) 336-2100
A subsidiary of HCA The Healthcare Company.

The cumulative data reported for 1986 indicates that HCA Medical Plaza Hospital's actual mortality rates run from the mid point of the range of predicted mortality rates to the low end of the scale, indicating that our hospital's actual mortality rate is well within the range of predicted mortality rates as determined by the Health Care Financing Administration.

We would like to further emphasize that the multiple factors including the severity of the illness, hereditary and socio-economic factors were not taken into account in HCFA's range of predicted mortality rates. Furthermore, the deaths counted may not be related to the hospital stay.

Again, thank you for the opportunity to present this response.

Sincerely yours,

Harold Berenzweig M.D.

Harold Berenzweig, M.D.
President of the Medical Staff

HB:dc

TX 306.1

Memorial City Medical Center
920 Frostwood
Houston, Texas 77024
932-3000

Provider #45-0610

October 27, 1987

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD. 21207

Dear Dr. Roper:

Thank you very much for the opportunity to respond to the Healthcare Financing Administration's mortality statistics tabulation. Data you have compiled concerning Memorial City Medical Center has been reviewed and validated by the various directors of the Medical Records/Quality Assurance, Utilization Review, and Risk Management Departments. Physicians on the Hospital's Utilization Review and Quality Assurance Committees have conducted a special review of a sample of the charts which you had identified. As Memorial City operates Memorial City Medical Center Hospital, a 520 bed acute care medical/surgical hospital, Spring Shadows Glen, a 156 bed psychiatric facility, Spring Shadows Pines, a 212 bed nursing home, and Memorial City Rehabilitation Hospital, a 62 bed rehabilitation hospital, we have the unique ability to follow and review the progress of these patients across the entire spectrum of care. These activities indicated, as did your statistics, that a vast majority of the mortalities were expected deaths and that those where death was not expected, were managed in an appropriate manner.

On an ongoing basis, the Quality Assurance Committee reviews every mortality occurring at Memorial City Medical Center Hospital for appropriateness of care. This mechanism provides us a continuous feedback source so that Memorial City Medical Center will continue to meet or exceed established quality care standards.

This year's incorporation of expected range of mortality is a dramatic improvement from previous statistical efforts. Because Memorial City Medical Center Hospital is a referral hospital, treating high-risk cases from the surrounding area, attracted by the high degree of technology on site and by an extremely active Emergency Center, a basis for comparing the

intensity of care provided is a welcome addition to your mortality statistics release. It is suggested that continued improvements be considered in the determination of expected mortality ranges so that not only will they demonstrate individual hospital achievement, but also become a valuable and reliable tool for comparison amongst hospitals.

Your care and concern in responding to the healthcare industry's suggestions and recommendations concerning this and your previous release of mortality statistics is greatly appreciated.

Yours truly,

Robert M. Bryant

Robert M. Bryant
Chief Executive Officer

RMB:df

cc: American Hospital Association
Texas Hospital Association
Greater Houston Hospital Council

MEMORIAL HOSPITAL OF GARLAND

2300 Marie Curie Garland, Texas 75042 214-276-9511

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Washington, D.C. 20201

RE: Mortality Data for Hospital 450280

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on mortality rates for Memorial Hospital of Garland for the period from January 1, 1986, through December 31, 1986, prior to public disclosure of this data.

Memorial Hospital of Garland is a 206 bed general acute care hospital which primarily serves Garland and other communities in northeast Dallas and surrounding counties. Our patients represent a wide range of medical and surgical illnesses. We are a full-service hospital offering care in the specialty areas of vascular diseases, gynecology, urology, orthopedic procedures, cardiology, psychiatry, as well as general medicine and surgery.

The Medical Staff of Memorial Hospital of Garland conducts intensive ongoing reviews of the medical management and quality and appropriateness of every patient who dies in our hospital. These types of reviews are an integral part of the hospital's quality assurance and medical peer review activities and are conducted on a monthly basis by each medical specialty department of the hospital's Medical Staff. Other reviews of overall hospital quality and appropriateness are conducted by physicians and other healthcare professionals who serve on the hospital's Quality Assurance and Patient Care Monitoring Committees. The hospital's quality assurance and patient care review programs are in compliance with the high standards set by the Joint Commission on Accreditation of Hospitals, which is the organization which reviews hospitals for their compliance with nationally accepted medical and managerial standards.

The specific mortality data for Memorial Hospital of Garland that was supplied by the Health Care Financing Administration (H.C.F.A.) was extensively reviewed by: hospital administrative staff, Chief of the Medical Staff, Physician Chairmen of the Utilization Review, Quality Assurance and Patient Care Monitoring Committees, Director of Quality Assurance, Director of Nursing, and Director of Medical Records. The data as reported by H.C.F.A. was found to be essentially correct according to hospital records.

In examining the data for Memorial Hospital of Garland, several factors should be noted which contribute to the mortality rates for our hospital. The first of these is the high percentage of patients who died in the hospital who, through their own request or a request by the next of kin in consultation with the physician, received orders that heroic measures not be taken to resuscitate them should they die, or "Do Not Resuscitate" ("DNR") orders. Of the 127 Medicare patients who died while a patient in our hospital, 63 percent had such orders. A second factor is the critical nature of many of these patients. Almost all of

the patients who died had additional complications or comorbidities which contributed to their death and presented additional problems not reflected in their primary diagnosis. The last factor is high volume of critically ill patients who are admitted to our hospital because of the location of our hospital in relation to other hospitals receiving emergency patients. Memorial Hospital of Garland is one of two hospitals serving a large area of Garland, Richardson, Plano and other communities in northeast Dallas, southern Collin and Rockwall Counties. As such, we receive a large number of transfers from smaller rural hospitals and nursing homes.

With respect to specific diagnostic categories, we would like to make the following comments:

GASTROINTESTINAL CATASTROPHIES

Memorial Hospital of Garland treated 33 Medicare patients in this disease category, of which 8 died within 30 days of admission. The predicted mortality range for our hospital was 6% to 33% and our actual rate was 24%.

It should be noted that:
* 5 of the 8 patients who died had DNR orders.
* 6 of the patients had 4 or more health conditions which contributed to their death.

LOW RISK HEART DISEASE

The predicted mortality range for patients at Memorial Hospital of Garland in this disease category is 2% to 14% and our actual was 10%. This represents 7 deaths out of 68 patients treated.

It should be noted that:
* Of the 7 deaths, 6 patients had 2 or more complications or comorbidities which contributed to their death.
* One patient was admitted through our emergency department in cardiac arrest and remained in critical condition throughout the patient's stay.
* Two of these patients made significant improvements and were discharged only to die several days later.

RENAL DISEASE

Memorial Hospital of Garland had a predicted mortality range of 9% to 76% with an actual mortality rate of 83%.

It should be noted that:
* All five patients had multiple complications and/or comorbidities which contributed to the patients' deaths.
* 4 of the 5 patients had DNR orders.
* One patient had an extensive history of cancer in multiple locations.

TX 311.1

SEPSIS

The predicted mortality range for this diagnostic category at our hospital is 16% to 62% and our actual rate was 56%.

It should be noted that:

* Of the patients who died in the hospital, 6 were admitted unresponsive or with limited responses.
* Of the patients that died, 8 had 4 or more complications or comorbidities which contributed to the patients' deaths.
* One patient left the hospital against medical advice.
* 6 patients were admitted in an unresponsive and semi-comatose condition, and of these, 5 died less than 24 hours of admission.
* 4 of these patients had DNR orders.

The Medical Staff of Memorial Hospital of Garland will continue to review all mortality cases for quality and appropriateness of the care rendered. The information obtained from these reviews is an important part of our efforts to provide quality care consistent with current medical knowledge.

Thank you for the opportunity to present these comments. If you or anyone receiving this information has additional questions, please do not hesitate to contact us.

Sincerely yours,

Gary D. Brock
Administrator

GDB/lg

TX 311.2

Memorial Hospital - El Campo
P.O. Box 1568, El Campo, Texas 77437
(409) 543-6251

October 22, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Washington, D.C. 20201

Certified Mail # P 580-022-205

Re: Medicare Provider Number: 45-0694

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for the calendar year 1986.

Memorial Hospital - El Campo is a 60 bed general acute care facility with a 4 bed Critical Care Unit located in a rural area of South Texas.

The hospital specific mortality data reported by H.C.F.A. has been carefully reviewed by a hospital committee created especially for the purpose of summarizing the findings. It was found that the actual mortality rate of our facility fell within the predicted ranges established by H.C.F.A.

The Committee selected six categories in which the following findings were reported:

1. Gastrointestinal Catastrophes

   Range of predicted mortality rates 13 to 54%
   Memorial Hospital - El Campo's actual rate = 22%
   75% of deaths were over age 84; 75% of cases involved multiple complications in addition to the principle diagnosis; in 100% of the cases, the family requested "No Code"*

2. Severe Chronic Heart Disease: Predicted 8-40% - Actual 39%

3. Severe Acute Heart Disease: Predicted 17-64% - Actual 57%

Due to similarities, statistics regarding these two categories were grouped as one.

59% of deaths were over age 75; due to severity of patients upon admission, 59% of deaths occurred within 24 hours of admission; 6% died outside our facility following discharge; 100% of patients admitted had multiple chronic complications; 24% of patient's families requested "No Code".

4. Pulmonary Disease: Predicted 11-40% - Actual 34%

   72% of patients over age 75 - of these, 63% over age 80; due to severity of conditions, 36% died within 24 hours of admission; all patients had multiple chronic complications along with their principle reasons for admission; 27% of deaths were cancer related; 9% of families requested "No Code"; 9% died outside our facility after discharge that were included in our totals due to this being the last institution in which the patient was hospitalized.

5. Sepsis:

   Predicted rate 9 - 80% - Memorial Hospital - El Campo's rate was 60%. 66.6% were over age of 80; 100% came from low socioeconomic conditions; 66.6% died outside our facility with a diagnosis unrelated to their primary diagnosis; 100% had multiple chronic complications; 66.6% were "No Code".

6. All Causes: [Other Category] Predicted 9 - 18% - Actual 16%

   80% of deaths were over 80 years old; 20% died outside our facility with diagnosis unrelated to their primary reason for being admitted to our facility; 100% had multiple chronic complications.

The remainder of the specific diagnostic categories were reviewed by our committee less extensively and due to the fact that within these categories the range of actual mortality rates were so low within the predicted ranges no findings were noted.

The Medical Staff and their appropriate committees conduct an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care.

Mortality review is an ongoing process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital. Due to our excellent Quality Assurance program and the excellent peer review process that is performed, our facility has recently

been awarded a 3 year Accreditation from the Joint Commission on Accreditation of Hospitals.

Memorial Hospital - El Campo is proud to be an institution which is totally dedicated to rendering top quality patient care.

Sincerely,

Dell Porth
Administrator

DP:ir

cc: Bill Hyslop, Regional Vice President, Memorial Regional Care
Karen Wells, ART, Director - Medical Records
Paul Stalker, Controller

* "No Code" is a medical term wherein the patient's family has requested that no artificial or extraordinary means be used to sustain life when death is inevitable.

Memorial Care Systems
7737 Southwest Freeway, Houston, Texas 77074

October 26, 1987

William Roper, M.D.
Administrator, Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26676
Baltimore, Maryland 21202

REF: Provider Number 450185

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of the Health Care Financing Administration (HCFA) data on hospital mortality rates for the 1986 calendar year.

Memorial Hospital System is a 1,100-bed, not-for-profit health care company affiliated with Memorial Care Systems, founded in 1907. Memorial Hospital System is composed of Memorial Southwest Hospital, Memorial Northwest Hospital, and Memorial Southeast Hospital--all acute-care facilities located in Houston, Texas. Major medical services provided include orthopedics, emergency centers, cardiac, physical rehabilitation, and respiratory care.

Memorial Hospital System has, and has had for many years, a quality assurance program in place to measure and monitor the quality of patient care in our hospitals. The monitoring of the quality patient care takes place in all departments of the hospitals, whether the department is directly or indirectly involved in the care of patients. All mortalities occurring in any of our hospitals are reviewed by the medical staff in order to assure that all appropriate measures were taken in caring for the patient.

The use of mortality statistics as an indicator of care in a hospital is not the measure of choice when used to assess quality of care rendered to patients. In fact, there are numerous indicators which, when used in combination, can then only begin to give the consumer a sense of the quality of care being delivered in a hospital.

We have reviewed the mortalities statistics as published for Memorial Hospital System, and we applaud HCFA in their attempt to provide information to the public. Memorial Hospital System has always been acutely aware of our responsibility to provide the best quality service to our patients, and will continue to provide the highest quality care possible.

Again, thank you for the opportunity to present this response.

Sincerely,

Kenneth J. Wine

Kenneth J. Wine, FACHE
Senior Vice President, Hospital Operations
Memorial Hospital System

COMMENTS TO HEALTH CARE FINANCING ADMINISTRATION MORTALITY DATA

MEMORIAL HOSPITAL
DUMAS, TEXAS
PROVIDER #50221

I. Comments for Each Diagnostic Category

A. Cancer - 11 total cases reported- 5 deaths reported for a mortality rate of 45%. All deaths were terminal patients admitted for pain management. All death cases were No-Code/Do Not Resuscitate.

B. Cerebrovascular Accidents - 5 cases reported - 2 deaths for a mortality rate of 40%. Both deaths were elderly individuals with a plethora of other medical problems. No-Code/Do Not Resuscitate orders were noted.

C. Gastrointestinal Catastrophes - 4 cases reported - 2 deaths for a mortality rate of 50%. Both patients were in their eighties. One had a massive GI hemorrhage and the other had bowel obstruction and peritonitis. In both cases, the family specifically requested that aggressive treatment be withheld. Both patients were No-Code/Do Not Resuscitate.

D. Gastrointestinal Disease - 38 cases - 1 death for a mortality rate of 3%. The one death was an 82 year old nursing home patient who, on admission, weighed 68 pounds. She was severely malnourished and dehydrated. A feeding tube gastrostomy was performed. She died twelve days after admission. No evidence of aspiration was noted at the time of her death. This patient's outcome was noted as being grave at the time of her admission.

E. Urological Disease - 3 cases - 1 death for an actual mortality rate of 33%. The one death case was an 87 year old chronically ill patient. She was treated for urinary tract infection at our hospital. She died at home a few days later with the cause of death being listed as acute myocardial infarction/severe coronary artery disease.

F. Low-Risk Heart Disease - 27 cases - 1 death. The actual mortality rate was 4%. The one death was a severely debilitated patient with profound vomiting and dehydration. She went into intractable atrial fibrillation and died. We question the inclusion of code 427.31 in "low-risk heart disease".

G. Severe Chronic Heart Disease - 11 cases - 6 deaths. Actual mortality rate was 29%. All patients were in the terminal phase of severe congestive heart failure. Of the six deaths, five were termed No-Code/Do Not Resuscitate. Patient [redacted] was discharged from the VA Hospital in Amarillo, Texas on January 30, 1986 and is erroneously listed on this facility's report.

H. Severe Acute Heart Disease - 11 cases - 8 deaths. Acute mortality rate 73%. The sample included two patients termed No-Code/Do Not Resuscitate. Three patients were aged 80 or above. Many patients had severe complications. Patient # [redacted] was discharged from the VA Hospital in Amarillo, Texas on November 20, 1986 and is erroneously included in this report.

I. Metabolic - Electrolyte Disturbances - 7 cases, no deaths. Mortality rate of 0%. No comment.

J. Orthopedic Disorders - 2 cases - 1 death. Actual mortality rate -50%. Case [redacted] was discharged from Northwest Texas Hospital in Amarillo, Texas on November 13, 1986 and is erroneously included in this report.

K. Pulmonary Disease - 47 Cases - 12 deaths. Mortality rate of 26%. Out of 12 death cases, 11 were termed No-Code/Do Not Resuscitate. In four cases, the family refused further definitive care and the patients were placed on what was essentially supportive therapy. Of the twelve cases, six were housed in nursing homes prior to hospitalization.

L. Renal Disease - 4 cases - 2 deaths. Mortality rate of 50%. Both cases were No-Code/Do Not Resuscitate with long standing problems admitted for terminal care. Case [redacted] appears to be a coding error. Patient had a massive cerebrovascular accident, diabetic coma, sepsis and secondary renal failure. Primary cause of death was cerebrovascular accident 434.0. Case # [redacted] was discharged from High Plains Baptist Hospital in Amarillo on 4-20-86 and was erroneously included in this report.

II. Comments

A. There is a real and obvious danger from drawing conclusions based on small sample sizes.

B. Our hospital does not have a means to readily verify the number of cases and coding included in HCFA's universe. In the future, we would request that such a listing be provided the hospital for verification.

C. It should be recognized that patients with fatal illnesses often receive treatment (chemotherapy, radiation therapy, surgery) at tertiary hospitals. They then return to their home communities to die. This fact is evidenced by the cancer deaths credited to our facility. Also in the rural communities our shortage of quality nursing home facilities often cause patients to die in the hospital rather than in an extended care facility.

D. Please note that our facility had a preponderance of No-Code/Do Not Resuscitate patients whose deaths were the expected outcome of care. Out of 44 deaths, 31 patients were placed in this category.

E. Please note that the hospital is a participant in the Medicare Swing Bed program, providing skilled nursing services. This increases the number of death cases that will occur at small rural facilities.

F. The hospital is credited with four deaths of patients that were transferred or discharged from other facilities. An effort needs to be made to ascertain if these patients are counted as deaths from both the transferring and receiving hospitals.

MEMORIAL MEDICAL CENTER
Office of the President

2606 Hospital Blvd.
P. O. Box 5280
Corpus Christi
Texas
78405

512/881-4000

WHEELER B. LIPES
President

D. BURK STRONG, M.D.
Chief of Staff

Board of Managers

GEORGE PETERS
Chairman

OSCAR H. REYNA
Chairman, Pro-Tem

ALVINO C. CAMPOS
ROBERT L. FORDTRAN, M.D.
XICO P. GARCIA, M.D.
SAM F. KEACH
WELDON A. RIPPY

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The mortality data concerning Memorial Medical Center has been reviewed. The data at Memorial Medical Center concerning Medicare patients is not the same as submitted by your office. There is no way to interpret and verify the accuracy of the information you have submitted on this hospital since we have no knowledge of the HCFA collection methods and the actions undertaken for interpretation and reporting.

Attached are comments for the December publication of the mortality data.

Sincerely,

Wheeler B. Lipes

Wheeler B. Lipes
President

cc
Chief of Staff
Chairman, Board of MAnagers

MEMORIAL MEDICAL CENTER

Office of the President

2606 Hospital Blvd.
P. O. Box 5280
Corpus Christi
Texas
78405

512/881-4000

WHEELER B. LIPES
President

D. BURK STRONG, M.D.
Chief of Staff

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Chairman, Pro-Tem

ALVINO C. CAMPOS
ROBERT L. FORDTRAN, M.D.
XICO P. GARCIA, M.D.
SAM F. KEACH
WELDON A. RIPPY

C O M M E N T S

H C F A M O R T A L I T Y D A T A

MEDICARE PROVIDER NUMBER: 450046

The list of patients used by HCFA shows that a total of 200 Medicare patients out of 1773 Medicare admitted to Memorial Medical Center died within 30 days of admission. The records at Memorial Medical Center indicate different admissions and deaths. Presumably the difference in data reflects possible multiple - admissions for Medicare patients or patient data is not accounted for correctly using the same periods of time or exclusion of patients from the count. We have no way of verifying whether the numbers are correct without detailed information concerning the data available to HCFA in their computing the mortality rate.

Memorial Medical Center offers services which attracts patients with a higher than average expected mortality, for example, severe massive trauma victims from accidents, cancer patients in terminal state of illness, heart patients with heart diseases that have high mortality rate, chronically ill patients with complicating conditions which usually result in death, etc. There are patients who are admitted knowing full well they have been admitted in order to die. There are other patients admitted to Memorial Medical Center with an acute or chronic condition at the time of admission and their expected outcome is death, however, when their death does not occur, it is usually the result of the extraordinary care and treatment provided by physicians on the medical staff of the hospital. Extraordinary efforts, available equipment and highly skilled personnel changes discharge outcome in many instances to recovery.

MEMORIAL MEDICAL CENTER
OF EAST TEXAS

October 20, 1987

William L. Roper, Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D. C. 20201

Re: Mortality Statistics, 1986

Dear Dr. Roper:

Memorial Medical Center of East Texas is a 254 bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. We are a full service medical center offering care in specialty areas of oncology, major orthopedic services, and dialysis, as well as general medicine and surgery.

The Mortality statistics released to us by your letter of September 21, 1987, have been reviewed and validated by our Director of Medical Records, and validated with only minor exceptions. On an on-going basis, appropriate clinical departments have always reviewed every mortality in our facility for appropriateness of care.

When reviewing the summary data tabulated by HCFA for Memorial Medical Center of East Texas, and when comparing these data between hospitals and with statewide data, it is important to recognize the following:

Pulmonary (PN): The hospital mortality rate for this category was 25% which is within the predicted range of 15-29%. Further review of cases within this category revealed 21% of the patients had a secondary diagnosis of carcinoma (Cancer). The carcinoma weakens the physical condition of the elderly patient and predisposes them to respiratory infections such as pneumonia. In the patients' weakened condition the body is unable to fight the respiratory infection and death can result.

P O Box 1447 • Lufkin Texas 75901 • (409) 634-8111

Severe Chronic Heart Disease (HM): The hospital mortality rate for this category was 30% which is within the predicted range of 16-34%. Review of the data revealed 31% of the deaths within this category occured within 24 hours of admission. The majority of these patients were from outlying communities and experienced a time delay in arriving at our hospital.

Fifty percent of cardiac deaths occur within 2 1/2 hours after onset of symptoms. Cardiac symptoms can be confused with indigestion, peptic ulcers, or gallbladder disease which can further delay a person seeking treatment. Consequently, the first few hours of treatment are essential for recovery.

Our hospital is very pleased to have been within the predicted range on each category covered by your statistics. The Clinical Staff of Memorial Medical Center of East Texas, as has been our practice, will continue to review mortality cases for quality and appropriateness of care rendered to the individual patient. Trending analysis from these reviews is a constant endeavor to assist identifying opportunities to improve care.

Thank you for the opportunity to respond to your data.

Respectfully,

Walter G. Deer
Executive Vice President
and Administrator

WGD:kgs
cc: Bettie Williams
Hilda Becerra

mesquite community hospital
3500 HIGHWAY 67 EAST
MESQUITE, TEXAS 75150
214/270-3300

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: Comments Regarding HCFA Mortality Data for Mesquite Community Hospital #450688

Dear Sirs:

Before commenting generally on the data reported on Mesquite Community Hospital, two instances of apparently incorrect data are identified for correction. First, patient ID [redacted] appears twice on the patient listing under the "all other" diagnostic category. Two different patient names are reflected under this patient ID, while all other data reported is the same. Second, patient ID [redacted] also listed under the "all other" diagnostic category is erroneous as the patient was discharged alive from this particular hospitalization, and the patient remains alive as of 10/15/87. Accounting for these incorrect entries reduces the reported actual mortality rate from 14% to 13%.

Mortality data reported by HCFA regarding Mesquite Community Hospital, and all health care facilities presents/reflects a relationship between a relatively small number of patients and patient characteristics and the risk of death, but there is no evidence that the method reliably predicts or reflects hospital mortality rates. The data itself fails to take into account a number of factors that have a significant impact on mortality such as the general health status of the patient, the stage of the particular illness, and the psychological condition of the patient. Said differently, the model utilized by HCFA does not consider what is termed severity of illness, has not been validated, and its meaningfulness is questionable. Deviations in a predicted mortality rate could easily be the result of certain evaluation factors such as those previously mentioned being excluded from consideration. The data developed and released by HCFA are not in themselves measures of hospital performance, and at best can only be used to better focus quality assurance activities already in place.

The fact that an individual hospital falls within, or outside the range of predicted mortality rates may or may not be statistically meaningful when using a questionable model. Data reported on Mesquite Community Hospital

shows that in all cases the actual mortality rate, within the diagnostic categories evaluated, fell within the range of predicted mortality rates. Though the data as reported may appear positive when compared to predicted ranges, the data says nothing of hospital specific mortality rates. The average age of patients who died either during their hospitalization or within 30 days post discharge was 80 years. The average age of patients who died during their hospitalization or within 30 days post discharge, who were originally admitted from a nursing home was 83 years, and fully 38% of the deaths reported in the categories evaluated were admitted from nursing homes. Severity of illness factors not considered in the HCFA model, reflect that 23% of the deaths occurred within 48 hours of admission, and in 46% of the cases there were valid "do not resuscitate" (DNR) orders on the medical record. DNR orders reflect a prearranged and fully discussed agreement between the physician and patient (or responsible family member or guardian) that heroic and/or resuscitative measures will not be taken should the patient suffer a cardiac or respiratory arrest. This latter statistic points to the quality of life issue, and certainly suggests that a higher percentage of patients admitted to hospitals today are more acutely ill and may by definition have a poorer prognosis on admission. Despite this, each death case is carefully reviewed as a part of ongoing quality assurance and peer review activities.

In summary, while data reported for Mesquite Community Hospital appears positive and within predicted ranges, only a statistically valid model that includes factors such as severity of illness will begin to address a true mortality rate instead of simply a "risk of death". The data reported does, however, have relevancy in pointing out possible areas of concern that hospitals may need to evaluate through existing quality assurance activities. The purpose of these quality assurance programs is to prevent problems from arising, or if problems do arise, to minimize or negate similar future occurrences. As a JCAH accredited hospital, quality assurance is a mandate strongly supported by our Board of Trustees, and accomplished through medical staff and hospital review functions. As such, Mesquite Community Hospital focuses its efforts towards ensuring the provision of high quality care.

Sincerely,

Raymond P. DeBlasi
Administrator

clb

mesquite physicians hospital

1527 NORTH GALLOWAY
MESQUITE, TEXAS 75149-2399
214-285-6391

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper,

Please find attached a letter to be released with the mortality data from Mesquite Physicians Hospital.

Please note that this letter reflects our official response and replaces a previous letter mailed to your office dated October 5, 1987.

Thank you for the opportunity to provide response concerning this important matter. If I can assist you in any way, please do not hesitate to contact me.

Sincerely,

Robert J. Templeton
Administrator

RJT:gv

Joint Commission on Accreditation of Hospitals

mesquite physicians hospital

1527 NORTH GALLOWAY
MESQUITE, TEXAS 75149-2399
214-285-6391

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear. Dr. Roper,

Thank you for this opportunity to respond to the release of data on Hospital Medicare Mortality Rates for 1986. We have conducted a detailed review not only of the mortality data received from your agency, but also of the specific medical record of every patient case mentioned in the report.

As will be noted by many sources throughout this process, these data alone are not an adequate measure of the quality of care at this or any hospital.

In fact, in a recent New England Journal of Medicine article, your agency's senior research physician wrote that even though case-mix (severity of illness) adjustments were made to the data being released, there is still no acceptable measure for outcome-oriented quality surveillance at this time. He noted that serious technical problems must be solved before we will be able to infer the quality of care for death rates or other outcome measures.

While the addition of the severity of illness measure increases the usefulness of these data versus the mortality report released last year, the measure still does not include the intensity or the number of comorbid conditions (defined as a pre-existing condition that would compound the medical problem). The data include only an indication of the presence of one or more comorbid conditions.

This shortcoming has important implications in the specific mortality data reported for our hospital. Our analysis produced the following percentages of Medicare mortalities, by number of reported comorbid conditions for those patients.

Joint Commission on Accreditation of Hospitals

American College of Physicians · American College of Surgeons · American Hospital Association · American Medical Association

Number of Comorbid Conditions	% of Patients
0	2%
1	35%
2	39%
3	15%
4	8%

The predicted mortality ranges in your report do not allow for multiple conditions or their intensity, only the presence or absence of one or more. The differential between projected and actual mortality data may not have to do with quality, but with having sicker patients.

A further measure of how sick patients are at a specific hospital is to look at how long after admission the death occured.

- If less than 48 hours after admission, a very serious condition may be indicated. (30% of Mesquite Physicians Hospital mortalities)

- If more than 20 days after admission, hospital patients that far above the average length of stay have a higher likelihood of dying. (13% of Mesquite Physicians Hospital mortalities)

This measure is not included in your agency's model of predicted mortality percentage.

In summary, the results of treatment are likely to be influenced by the seriousness of the illness, how advanced a stage the illness has reached, and the general health status of the patient that allows him to resist the disease and respond to treatment. Of all the patients reported in our hospital's Medicare Mortality Data, 95% were admitted from nursing homes, suggesting a significant level of sicker patients.

Regarding accuracy of the data presented in this report, we found that for 3 mortalities attributed to our hospital, the death actually occured in another hospital. Additionally, one patient reported as having expired at our hospital on August 31, 1986 is still alive.

While there are serious limitations to the data supplied in the mortality report, Mesquite Physicians Hospital supports the principle of communicating meaningful quality of care information to consumers. Mortality review is something this hospital already performs, and is an important part of our quality control program.

TX 327.2

Our utilization review/quality assurance procedures include adherence to specific admission and discharge criteria as well as a concurrent review during the hospital stay. Any deviations from established standards results in a peer review by a physician committee. It is our objective to implement the highest standard of medical care for the community we serve, and to continually monitor our own performance.

Thank you for this opportunity to add this statement to the release of our data.

Sincerely,

Robert J. Templeton
Administrator

RJT/sc

TX 327.3



METHODIST HOSPITAL

October 26, 1987

Hospital ID# 450457

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to provide comments on the HCFA supplied mortality data on Medicare patients treated at Methodist Hospital during 1986. Before offering our comments on the data, a brief description of Methodist Hospital appears to be indicated.

The Hospital is the largest in West Texas. It is a general, acute care, not-for-profit hospital owned and operated by Methodist Hospital. The Hospital has a licensed capacity of 715 beds and is a full service medical center offering care in specialty areas of oncology, open-heart surgery, major orthopedic services, rehabilitative medicine, dialysis; as well as general medicine and surgery.

The Medical Staff of Methodist Hospital conducts an intensive review of the medical records of each patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare services offered at this hospital. The Joint Commission on Accreditation of Healthcare Organizations bestowed on this facility its highest commendation during the last survey.

The hospital specific mortality data has been carefully reviewed by the hospital administrators, Chief-of-the-Medical Staff, Physician Chairman of the Utilization Review Committee and Quality Assurance and the Director of Medical Records/Quality Assurance.

Regarding the data specifically. We were pleased to learn that the actual mortality rate for each of the 16 categories, as well as for the "all causes" category, fell within the range of predicted mortality for Methodist Hospital. In fact, actual rates typically fell in the lower to middle portion of the predicted range.

P.O. Box 1201 3615 19th Street Lubbock, Texas 79408 (806) 792-1011

The category of sepsis, while still within the predicted range, did appear in the upper end. This situation merited our attention. Research on the DRG Septicemia, revealed the average age of the patients to be 82.08 and that 46.15% of the admissions were from nursing homes. All patients were admitted with sepsis from urinary tract infections or respiratory infections. All patients had multiple conditions; for example, chronic obstructive pulmonary disease, arteriosclerotic heart disease, chronic urinary tract infection, Alzheimer's disease, Parkinson's disease, cirrhosis, leukemia, breast cancer, acute phelonephritis, severe hemolytic anemia.

As a tertiary care facility with more than 80 intensive care beds, Methodist Hospital typically treats the sickest patients in the region. Since this is the case, we naturally expect a certain number of deaths. However, each death is a serious concern and the Medical Staff and management of the Hospital have committed themselves to high quality assurance standards.

The data HCFA provided is helpful and we thank you for your interest in improving our nation's hospital system.

Sincerely,

William D. Poteet, III
President

Travis Casler, M.D.
Chief of Staff

WDP:pm

cc: Tim Hatch, Chairman of the Board

METHODIST HOSPITALS of Dallas
Post Office Box 655999 Dallas, Texas 75265-5999

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
6325 Security BLVD
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to provide input on the Health Care Financing Administration (HCFA) mortality information for Methodist Medical Center for the calendar year 1986. The following information for Methodist Medical Center is to be attached to the Hospital Specific Report in connection with public disclosure.

Methodist Medical Center is a 508-bed acute care and teaching facility. It is the sixth most active referral center for kidney transplantation in the nation, has one of only two Level I trauma centers in Dallas, and serves as home base for the city's only air ambulance service. By the nature of these and other services, Methodist treats a large percentage of severely ill and injured patients.

The quality of care is of utmost concern to Methodist Medical Center's governing board, medical staff and management. There is a comprehensive ongoing review and assessment of care which begins with patient admission and continues through the completion of the hospital stay. Following discharge, a quality review of each medical record is conducted. As part of its commitment to quality, the medical staff closely reviews the medical record of every patient who dies at this facility. The medical management and overall care is evaluated and discussed by an independent group of physicians. Mortality review is a regular function of the Quality Assurance program, and various other physician review activities are an integral part of the ongoing monitoring of patient care.

The mortality data reported by HCFA have been reviewed by the entire Committee on Utilization Review and other members of the medical staff. Additional reviews were conducted by the Director of Medical Records, Director of Quality Assurance and members of the Medical Center's administration.

A summary review of the data revealed that 2,692 cases were reported in the HCFA study. Of the number of cases reported there were 345 deaths (13 percent). This is two percentage points below the range of predicted mortality for "all causes." Seventy-nine deaths (23 percent) occurred following discharge from the hospital.

Further review indicates that the HCFA data reflect quite favorably on the quality of care at Methodist for patients suffering from Renal (kidney) Disease. Of the 86 cases listed in the study, seven (eight percent) actually died, whereas HCFA predicted a mortality rate as high as 32 percent. Since Methodist is a major referral center for these patients, the results are even more remarkable inasmuch as these patients are often at the most critical point of their illness when admitted here.

The mortality rates are also favorable in the Urologic Disease category. Of the 101 cases there were six (six percent) deaths, but the range of predicted mortality was estimated to be as high as thirteen percent.

In all but two categories, the actual mortality rate was below the range of predicted mortality as defined by the HCFA methodology. We will address those two categories in the remainder of this report.

In the category of Pulmonary Disease, the average age of the patients who died was over 77.3 years and for 35 patients (80 percent of the total), the patient and family, along with the physician, agreed that no heroic measures should be performed in the event of cardiac or pulmonary failure. Fourteen patients (32 percent) were admitted directly from nursing homes. In addition to the principal diagnosis, each of the 44 patients that died had an average of nearly four significant additional medical complications, attesting to the severity of their illness.

In the category of Metabolic/Electrolyte Disturbances, the average age of the patients who died was almost 75 years, and 24 patients (86 percent) reflected that the patient and family, along with the physician, agreed that no heroic measures should be performed in the event of cardiac or pulmonary failure. Twenty-one percent of the patients were admitted directly from a nursing home. In addition to the principal diagnosis, each of the 28 patients had an average of 4.55 significant additional complications, attesting to the severity of their illness.

Methodist Medical Center continues to be committed to providing high quality patient care. We appreciate the opportunity to present this information along with the release of the data.

Kindest regards,

John W. Carver
Executive Director

L. Dwight Lind M.D.
President, Medical Staff

JWC/bkv

TX 329.2

METROPLEX
HOSPITAL

October 26, 1987

Dr. William L. Roper, Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for providing the opportunity to introduce comments addressing the mortality data release for our hospital.

Metroplex Hospital is a 78-bed, general acute care community hospital serving the needs of a large, mostly rural area of Central Texas. The patient mix of our facility includes a very wide spectrum of illnesses and injuries from all types of payor groups including Medicare, Medicaid, Blue Cross, commerical insurance, Champus, HMO/PPO's, self pay, and charity. A significant proportion of our Medicare admissions are nursing home patients who usually have multiple medical conditions, indicating a higher level of severity of illness upon admission.

The Quality Assurance Committee at Metroplex Hospital reviews the medical records of all patients who die in the facility, not just Medicare patients. This review for medical management and overall care is part of the on-going monitoring of the healthcare delivery system at the hospital.

The hospital's 1986 Medicare mortality data which you sent in September 1987 has been reviewed by hospital administration, the Directors of Quality Assurance, Medical Records and Utilization Review and was presented to the medical staff. Our analysis indicates our overall percentage of deaths was within the predicted range of mortality rates with only two high risk areas showing high mortality rates. In the low risk categories, our actual mortality rate was consistently at the low end of the predicted range.

2201 SOUTH CLEAR CREEK ROAD KILLEEN, TX 76542 (817) 526-7523/547-6677

Our analysis of the data indicates a couple of further observations which should be noted. First, the number of admissions and deaths in any specific group is quite low, making statistical significance difficult to calculate. Second, several of the patients died after being discharged which makes it difficult to determine whether the cause of death was the same as the diagnosis at the last admission.

Furthermore, multiple system chronic disease processes and severity of illness were contributing factors in the majority of these mortalities, such as in the case of the four deaths from renal disease. All four patients had terminal end-stage renal disease with other chronic disease processes contributing to the severity of illness on admission. In many of these terminal cases the patient or family had requested a "do not resuscitate" status.

Age was also one of the variables in the formula to calculate the predicted range of mortality rates. In our case fifty-two per cent of the mortalities were eighty years or older. In the case of the renal disease deaths, three of the four mortalities were in the highest age category, with one patient being 96 years old.

As previously stated, review of patient treatment by this hospital is an on-going occurrence in a constant endeavor to improve the quality of care to our patients. We appreciate the opportunity to analyze and respond to this report on a review of a specific segment of our patient population.

Sincerely,

Norman L. McBride

Norman L. McBride
President/CEO

/sak

Metropolitan Hospital

Health Care for the Whole Family

7525 Scyene Road Dallas, Texas 75227 Telephone (214) 381-7171

October 5, 1987

William L. Roper, M.D., Administrator
Department of Health and Human Services
Washington, D.C. 20201

Re: Provider #45-0704 Mortality Data-1986

Dear Sir:

Thank you for allowing us the opportunity to preview our hospital's mortality data for 1986. After careful review of the data you have compiled, we would like to make the following comments:

1. Patient [redacted] was transferred to Baylor University Medical Center on 12-26-87, four (4) days prior to his death, for tertiary services and therefore should not be reflected in figures relevant to Metropolitan Hospital.

2. Sixteen (16) of the thirty-nine (39) patients listed as having died within thirty (30) days of admission to our facility had physician's orders indicating that the family and physician agreed that no extraordinary measures be used to prolong the patients' lives. This number represents forty-one percent (41%) of all patients listed and is directly related to the terminal condition of these persons at the time of admission.

Again, we appreciate the opportunity to review and comment on this study.

Regards,

Steven J. Peterson
Administrator

c: Joseph Dubin, D.O., Chief of Staff

AMI Mid-Jefferson County Hospital

October 27, 1987

Medicare Provider # 450514

Mr. Harvey Brook
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
6300 Security Boulevard
Room 2D2 Meadows East Building
Baltimore, Maryland 21207

Dear Mr. Brook:

Mid-Jefferson Hospital is a 126 bed acute health care facility holding a three year accreditation from JCAH. Our case mix includes general medicine and surgery as well as a high level of obstetrics.

The September 21, 1987 HCFA Mortality Data was validated as accurate by the Director of Medical Records at Mid-Jefferson. The Director of Quality Assurance has also reviewed all medical records reflected in this report.

In addition, on an ongoing basis, it is the responsibility of the Utilization Review Committee of the Medical Staff, which includes five members of the medical staff to review every mortality in our facility for appropriateness of care.

For the HCFA Report a total of 680 Medicare admissions were analyzed of which 16% died. The predicted mortality range for our facility was from 10 to 17%. Based on a review of the data, the following summarizes our findings for the 16 categories analyzed:

Diagnostic category: Gastrointestinal disease - (a low risk group)

A total of 76 patients were treated which represents 11% of the total patients reviewed and only 1% died. The predicted mortality range for this category for our facility was from 2 to 13%. This reflects the high quality of care and medical staff at Mid-Jefferson Hospital.

Diagnostic category: Severe chronic heart disease - (a high risk group)

A total of 32 patients were treated which represents 4.7% of the total cases reviewed. The actual mortality rate for this category was 44% representing 13 deaths. The predicted mortality rate for this category is from 11 to 41%. The average age of these patients was 80.6 years and three of the mortalities occurred an average of 13.3 days after discharge.

There were two patient mortalities under the age of 65 included in the analysis. One patient had severe chronic obstructive pulmonary disease and the patient and family requested that no extraordinary means be utilized to maintain life. The second patient had multiple conditions contributing to their death including severe diabetes. This patient had undergone an amputation and was under treatment at a teaching facility in a major medical center.

Our hospital medical staff committees monitor every mortality on an ongoing basis. This system provides us with a mechanism to continue to meet and exceed quality care standards.

Sincerely,

JOHN C. GROSSMEIER
Executive Director

DOUGLAS WHEELER, M.D.
Chief of Staff

JCG:wfl:177

MIDLAND MEMORIAL HOSPITAL
MMH

Executive Offices
2200 West Illinois
Midland, Texas
79701
(915) 685-1111

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, DC 20201

Re: Mortality Statistics 1 January 86 thru 31 December 86
Midland Memorial Hospital, ID #450133

Dear Dr. Roper:

Thank you for the opportunity to review and respond to the hospital mortality statistics supplied with the letter dated 21 September 1987. Since receipt of that letter, the staff of Midland Memorial Hospital has reviewed the data.

Midland Memorial Hospital is an acute-care facility licensed for 272 beds. Care is offered in the specialty areas of treatment for cancer, as well as in general medicine, surgery, obstetrics, and pediatrics. The hospital is accredited by JCAH, having been awarded a 3-year accreditation based on a survey performed in April, 1987.

The data supplied by HCFA were analyzed by a team composed of the physician chairman of the Utilization Control Committee, the Director of Medical Records, the Director of Planning and Marketing, and the Vice President of Medical Affairs. Initially, the data were compared to hospital records and found to be substantially correct. The major difference was that five deaths were found in the hospital records which should have been included in the HCFA data. One death was not noted as such in the hospital's billing process. The other four were not reported by HCFA for reasons unknown.

Attention next was directed to the only one of the sixteen categories in which the number of deaths exceeded the predicted mortality range for that set of patients. Pulmonary (lung) disease deaths were 32% compared to a predicted mortality range of 13-30%. The medical records of all 32 patients who died were reviewed, as were 32 records from the 69 patients who survived. The records of those surviving were matched by principal diagnosis to those who died. It was hoped that by such a comparison, an explanation could be found if one existed.

Similarities in the patients who died as compared to those who did not were noted as follows:

- o The incidence of concurrent illness other than the lung problem appeared to be approximately the same in both groups, although the adverse outcome of those who died obviously would suggest greater severity of both the principal and secondary illnesses;

- o the average length of stay (ALOS) for the patients who died was similar to those who recovered--9.6 and 10.4 days respectively. Eight of the 32 patients who died did so within the first 48 hours of admission;

- o essentially the same group of physicians treated all the patients with lung disease, whether the patients died or not.

Differences in the two groups of patients were noted as follows:

- o the average age of the patients who died was slightly greater—80.3 years compared to 75.3 years for the audited group who survived;

- o "Do Not Resuscitate" orders were written for 22 of the patients who died; 7 were written at the time of admission, and 15 others were written during the course of their hospitalization. By contrast, only 2 of the audited group of surviving patients had a "Do Not Resuscitate" order written; and

- o of the 32 patients who died, 13 came to the hospital from a nursing care facility, whereas only 4 of the group of survivors audited came from a nursing care facility. One could anticipate that patients requiring support from a nursing care facility would be in worse condition than those still capable of living at home.

The differences noted between the patients who died and the analyzed group of survivors suggest that while the principal and concurrent illnesses were similar in both groups, the severity of the illnesses was greater in the group who died. In the absence of a system to document severity of illness, we were unable to draw any further conclusions. No negative patterns of care were identified to account for the number of deaths being slightly higher than anticipated in this illness category.

Trend analyses of data such as these provide assistance in identifying opportunity to improve care. The Medical Staff will continue to review all mortality cases for quality and appropriateness of care to individual patients, as they have done for some time.

Sincerely,

James Humphreys, MD

James M. Humphreys, Jr., M.D.
Vice President/Medical Affairs

MILAM REGIONAL **MRMC** MEDICAL CENTER

October 8, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

I have reviewed the mortality information sent to Milam Regional Medical Center. Attached is our response to the category Milam Regional Medical Center (hospital = 450122) did not fall within the range of predicted mortality rates.

If this information is not acceptable, please advise.

Sincerely,

Thomas E Wood/gb

Thomas E. Wood
Executive Director

TEW/gb

Enclosure

P.O. Box 795 • 512 N. Jefferson • Cameron, Texas 76520 • (817) 697-6553

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

MOTHER FRANCES HOSPITAL
REGIONAL HEALTH CARE CENTER

October 19, 1987

Department of Health and Human Services
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207
Attn: William L. Roper, M.D., Administrator

Dr. Roper,

We appreciate your efforts in the compilation of this data, and we welcome the opportunity to provide the consumer with an analysis of our mortality rate statistics.

We have reviewed the data and find that our actual mortality rate for Medicare cases during the calendar year 1986 are well within the range of mortality rates predicted by HCFA for our hospital.

It is our policy for these statistics to be reviewed by the appropriate medical staff entities within the course of carrying out our quality assurance program. In conjunction with the medical staff policy, Mother Frances Hospital has in place a program for reviewing the quality and appropriateness of care whenever mortality occurs.

Our monitoring system has been evaluated and commended by both Medicare and the Joint Commission on Accreditation of Hospitals.

It is important that any reviewer of these figures be aware of the many variables that should be considered in each case such as age, severity of illness, existing medical complications, and procedures. Because patient population varies from one hospital to another it is difficult, and inappropriate, to compare statistics.

We appreciate the opportunity to contribute to this publication. Mother Frances Hospital has served East Texas for 50 years, and we believe that contributing to public awareness fits with our long tradition of service and care.

Sincerely,

J. Lindsey Bradley, Jr., FACHE
President

800 East Dawson • Tyler, Texas 75701 • (214) 593-8441

TX 334.1

AMI Nacogdoches Medical Center Hospital

October 22, 1987

Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Statistics
October 1, 1984 - September 30, 1986

Provider Number: 450-656

Dear Sir:

Thank you for this opportunity to respond to the release of data on hospital mortality rates. Since receiving the report dated September 21, 1987 AMI Nacogdoches Medical Center staff has had an opportunity to review the data.

The Director of Medical Records has validated that the data is accurate. The Director of Quality Assurance has also reviewed all cases reflected in this report.

It is to be noted that the mortality rate for our facility in any of the diagnostic categories mentioned are within the predicted mortality range.

AMI Nacogdoches Medical Center and its medical staff perform ongoing review of mortality cases for appropriateness and quality of care. These reviews assist us in identifying opportunities to improve our services.

This facility supports the principle of communicating appropriate and meaningful quality of care information to the consumers. We also welcome the opportunity to discuss the quality of care provided by this hospital.

Again, thank you for the opportunity to comment on the mortality data.

Sincerely,

Bryant H. Krenek, Jr.
Executive Director

4920 N.E. Stallings Drive, Nacogdoches, Texas 75961 409 569-9481
Post Office Box 1604, Nacogdoches, Texas 75963-1604

HCA Navarro Regional Hospital

Comments on the HCFA Mortality Data

Navarro Regional Hospital

Corsicana, Texas

Medicare Provider # H04504470

Data Verification:

The data used by HCFA indicate that of a total of 1,634 Medicare patients admitted to Navarro Regional Hospital in 1986, 190 died within 30 days of admission. Statistics generated through review of Navarro Regional Hospital records indicate that 2,496 Medicare admissions occurred in 1986. Presumably, the discrepancy between HCFA data and Navarro Regional Hospital statistics reflects multiple admissions of individual beneficiaries to this Hospital.

Navarro Regional Hospital records indicate that of the 190 Medicare deaths attributed to the Hospital by HCFA, 147 died while still a patient of the Hospital, while 43 died after discharge. The deaths of two patients that HCFA indicates died after discharge cannot be verified, as information concerning death after discharge is not included in the patient's medical record and efforts to verify the deaths have been unsuccessful.

Interpretive Remarks:

In all of the diagnostic categories used by HCFA, Navarro Regional Hospital's actual mortality rate falls within the range of the predicted mortality rate. Additionally, in 8 of the diagnostic categories, the Hospital's actual mortality rate was at the low end of the range of predicted mortality (Ophthalmologic Disease, Gastrointestinal Catastrophies, Gynecologic Disease, Renal Disease and Severe Trauma). In none of the diagnostic categories was the Hospital's actual mortality rate at the high end of the range of the predicted mortality rate.

If the actual mortality rate is corrected to reflect the fact that there were 2,496 Medicare admissions in 1986, the actual Medicare mortality rate for Navarro Regional Hospital would be 7.6%, rather than the 12% indicated in the HCFA study.

Assumptions not identified in the HCFA model could have adversely impacted the mortality rates of Navarro Regional Hospital. For example, although the HCFA model lists deaths by principal diagnosis, review of patient medical records indicates that patients died of causes involving multiple associated diseases other than the principal diagnosis.

3201 West Highway 22
Corsicana, Texas 75110
Telephone (214) 872-4861
A subsidiary of HCA The Healthcare Company

Unique Services That May Result in Increased Mortality Rates:

Navarro Regional Hospital is a designated Regional Rural Referral Center. It is the only hospital in Navarro County, Texas and attracts patients from a primary service area with a population in excess of 65,000. An active, Level II emergency room attracts patients of all severities of illness from the entire service area of the Hospital, as well as severe trauma from major highways that pass through Corsicana.

The specialties represented on the Medical Staff of the Hospital are consistent with the Hospital's designated Referral Center status. These specialties result in patients being treated in the Hospital with more intense medical needs than non-Referral Center hospitals. This could have an adverse impact on the total number of expected and actual Medicare deaths.

The absence of skilled nursing beds, rehabilitation beds and hospice beds in Navarro County could result in an adverse impact upon Navarro Regional Hospital's death rates. Hospitals with adequate skilled nursing facilities, rehabilitation services and hospice programs discharge patients to those alternative delivery mechanisms when the acute care needs of the patient have been met by the Hospital. However, many patients remain as patients in Navarro Regional Hospital because of the absence of these services.

The percentage of patients in the Navarro Regional Hospital service area who are over 65 years of age is a significantly higher percentage than the national average. This results in more Medicare admissions per capita, which could have an adverse impact on the total number of expected and actual Medicare deaths.

Results of Preliminary Medical Record Review:

The Mortality Data for Navarro Regional Hospital reported by HCFA has been carefully reviewed by the Hospital Administrator, the Director of Medical Records and the Quality Assurance Committee of the Medical Staff. In each instance, the medical management and overall care of the patient was determined to be appropriate. Additionally, review indicated that the death of each patient was not an unexpected event due to either the general condition of the patient upon admission or other associated diseases experienced by the patient but not recognized by the HCFA model. For example, although the HCFA model only adjusted for one complication/comorbidity for patients, 184 of the 190 (97%) Medicare patients who died in Navarro Regional Hospital had two or more complications and/or comorbidities.

Preliminary Medical Record Review also indicated that family members of 47% of the Medicare patients who died requested that resuscitative efforts not be attempted should the patient die, indicating that patient death was a potentiality anticipated, even upon admission. Thirteen of those patients died after discharge from the Hospital.

The Medical Staff at Navarro Regional Hospital conducts an intensive medical management review of the Medical Record of every patient who expires at this Hospital. The mortality review is an on-going process of the Quality Assurance Program, and Peer Review Activities are an integral part of the monitoring of the healthcare delivery system at Navarro Regional Hospital. The Joint Commission on the Accreditation of Hospitals bestowed on this Hospital its highest commendations for the Hospital Quality Assurance Program and the excellent Peer Review Process that is performed.

Nix Medical Center

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Adminstration
Washington, D.C. 20201

Dear Doctor Roper:

The Nix Medical Center is a 208 bed acute care facility and ambulatory surgical center. We are a full service medical center offering care in obstetrics, orthopaedics, ophthalmology, open-heart surgery, diabetes, cancer, gastrointestinal diseases, hyperbaric medicine, respiratory diseases as well as general medicine and surgery. In addition, we have high tech radiology and laboratory support.

The Nix Medical Center serves as a primary care as well as a referral center for San Antonio with one of the highest percentages of board certified physicians inclusive of all specialties and sub-specialties.

The Medical Staff at the Nix Medical Center has always and continues to conduct an intensive review of the medical record of every patient who expires at this facility with respect to the medical management and overall care. This process is an integral part of the hospital's Quality Assurance Program which has been established to assure that only the highest standards of care are being maintained.

The hospital's mortality data reported by the Health Care Financing Administration has been carefully reviewed by the Chief Executive Officer, President of the Medical Staff, Chairman of the Executive Committee, Chairman of the Quality Assurance Committee, and Director of Medical Records. It is our consensus that the Nix represents a small comprehensive health care facility who provides quality medical care with state-of-the-art technical support.

414 Navarro • San Antonio, TX 78205 • 512/271-2188

The Medical Staff of the Nix Medical Center will continue to review and monitor for quality and appropriateness of care rendered to our patients.

Thank you for the opportunity to present this response.

John F. Strieby
President & Chief Executive Officer

William L. Sammis, M.D.
President of the Professional Staff

TX 347.1

AMI North Texas Medical Center

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
300 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

AMI North Texas Medical Center is a 168-bed acute care facility, located in a rural area, whose mix of patients includes many who are elderly and indigent. These patients have major medical and surgical illnesses, and many of them postpone seeking medical care until they are gravely ill. Many of the procedures we perform here, and the technology we offer, are of a higher acuity than other hospitals our size in similar demographic areas.

After careful review of the HCFA Hospital Mortality Data by members of our Medical Staff Executive Committee and Quality Assurance Staff, I can verify that your statistics are correct according to hospital records.

In 15 of 16 diagnostic categories, North Texas Medical Center's Actual Mortality Rate fell within the Range of Predicted Mortality Rates. In two categories, Orthopedic Disorders and Gynecologic Disease, our hospital had an Actual Mortality Rate of zero. Only one diagnostic category, Pulmonary Disease, fell outside the Range of Predicted Mortality Rates.

After a comprehensive review of the HCFA data and individual patient charts by members of our Quality Assurance Staff (including our director of quality assurance, DRG coordinator and UR coordinator), it has been determined that the majority of patients included in the statistics for the Pulmonary Disease diagnostic category had a high number of complicating conditions. We believe this contributed significantly to the high Actual Mortality Rate in this particular category.

Although we have found the HCFA data to be of assistance in screening cases for further review, it is but one quality assessment tool in our hospital's effective quality assurance system.

North Texas Medical Center has an ongoing quality assurance program, of which peer review activities are an integral part. ALL deaths are reviewed by our Medical Staff, on a monthly basis, for quality and appropriateness of care. We believe that our quality assurance program provides us with the timely information we need to continue to maintain our high quality care standards and delivery of service.

Thank you for affording us the opportunity to comment on these statistics.

Sincerely,

Steve Woerner

Steve Woerner
Executive Director

SW/er

Medicare Provider Number 450403

Northeast
Medical Center
Hospital

October 27, 1987

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
Washington, DC 20201

Hospital Provider Number: 450684

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on specific mortality rates for Northeast Medical Center Hospital, Humble, Texas.

Northeast Medical Center Hospital is a 237 bed, not-for-profit, general acute care facility serving northeast Harris County. Our number one commitment is to provide our patients and their families with healthcare services of the highest quality, from sophisticated trauma and emergency care services to the latest in diagnostic equipment, facilities, and treatment techniques. Northeast Medical Center Hospital is 1) accredited by the Joint Commission on Accreditation of Healthcare Organizations, and 2) a member of the American Hospital Association, the Texas Hospital Association, the Greater Houston Hospital Council, and other service organizations within the community it serves.

An extensive review of the medical records of every patient who expires at our facility regarding medical management and overall care has always been conducted. Mortality review is an on-going process of the Quality Assurance program, and peer review activities are an integral part of the monitoring of the healthcare delivery system. In addition, over 50% of these records have been reviewed by the Texas Medical Foundation, the Peer Review Organization for the State of Texas, for quality and appropriateness of care.

The hospital specific mortality data reported by the Health Care Financing Administration has been carefully reviewed and validated. We are pleased to note that except for a few minor discrepancies the data released is accurate.

We are also pleased that Northeast Medical Center Hospital was within its predicted range of mortality for all but one of categories identified in this report. It must be noted however, that the diagnostic catagories indicated in the hospital specific percentages do not necessarily reflect the actual cause of death.

After careful review of this information by our staff, we would like to offer the following comments which summarize our findings and provides an interpretation of the selected mortality information for Northeast Medical Center Hospital.

- 10% mortality rate for cases from all causes; 15% of the actual deaths occurred outside our facility. Of these, 26% were transferred to a hospice for the terminally ill, 37% to a nursing home, 21% to another type of extended care facility, and 16% returned to their own homes at their request. The average age of these patients was 80 and the information gathered from the medical record indicates that death was the expected outcome from their disease process.

- 38% or 21 cases were reported as cancer deaths; 81% were attributed to cancer of the lung and the disease had reached its terminal state. After review, it was found that the average age was 75 years old and 88% of these cases had requested that no extra-ordinary measures be taken to prolong life.

- The deaths resulting from severe heart disease, (56%) were slightly above the predicted range for our facility. The location of our hospital on a major north - south thoroughfare and designation as the emergency facility for Houston Intercontinental Airport are contributing factors to this statistic. The great majority of these were brought in through the hospital emergency department and 95% had suffered from a severe heart attack before reaching our facility. A large number of the total (95%) also suffered from another medical condition which contributed to their death. Even though a well-trained team of healthcare professionals was on hand, and in many cases successfully resuscitated the patient in the emergency department, death was the expected outcome of their disease. It should also be noted that 32% of these cases did wish that no extra-ordinary measures be performed to prolong their life.

The Medical Staff of Northeast Medical Center Hospital as has been their practice, will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient.

In conclusion, again, we express our thanks at being given the opportunity to comment on this report. The analysis from this review will serve as another positive step in our constant endeavor to improve healthcare.

Sincerely,

Monty E. McLaurin
Administrator

Robert Morrow, M.D.
Chief of Staff

ME:RM:ll

TX 351.2

OAK CLIFF
medical &
surgical hospital

233 West 10th at Madison • P.O. Box 4446 • Dallas, Texas 75208 • (214) 946-5191

October 22, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Washington, D.C. 20201

RE: HCFA Mortality Data Release

Dear Dr. Roper:

Oak Cliff Medical and Surgical Hospital would like to take this opportunity to respond to the Mortality Data Release Information that we received September 23, 1987.

Although our actual Mortality rate was within the acceptable range in all areas we feel there are some discrepancies that need to be addressed.

First, the statistics for overall Medicare patients admitted to our facility were not totally correct. Our statistics reflect 692 Medicare admissions for 1986. This would place our mortality rate at 7%.

Even though you based your information on the last hospital admission of the year for Medicare beneficiaries, we feel that it has a definite bearing on the Mortality rates on the whole. Many Medicare Beneficiaries have multiple illnesses requiring several hospitalizations during the last year of their life.

I feel it is necessary to point out several areas of concern reported in the data based on our review of the findings reported on the 49 deaths:

1) Eight patients expired after discharge. Three reportedly died the day after discharge. One of these was reported incorrectly as the date of death which was the day of discharge, that is, the patient expired in the hospital.

2) The other 2 reported deaths the day after discharge:
   a. Patient Acct. [redacted] 72 year old patient admitted 2 days post motor vehicle accident, patient was seen at another facility and diagnosis was chest contusion and patient was released. Patient was admitted to our facility with diaphoresis and severe shortness of breath. Patient was hospitalized for four days and was discharged home in stable condition, after meeting discharge criteria.
   Discharge Diagnosis: Chest pain due to fracture of right rib and contusion of lung; Early Congestive Heart Failure due to Coronary artery disease: Hypertension
   Category was listed as Unknown (fracture of rib)

CODING PROBLEMS:

3) Patient account [redacted] 86 year old admitted from family home with Acute Gastrointestinal Bleeding from undetermined site, Malnutrition and Severe Arteriosclerotic Heart Disease.
   a. Family refused transfusion of platelets, patient was senile.
   b. Patient was hospitalized for 5 days and was discharged to family's care after meeting discharge criteria.

There was a problem that the reported code was listed as 285.0 (anemia) which placed this patient in an unknown category. This code was not the principal diagnosis which was the Acute Gastrointestinal Bleeding.

4) Patient account [redacted] Another coding problem questioned was an 86 year old listed in the unknown category with a code of 239.1 (neoplasm of the respiratory system)
   Patient was admitted with history of severe shortness of breath, right sided chest discomfort, outpatient chest x-ray indicated opacity of the left lower lobe, highly suggestive of malignancy, and bilateral pleural effusion.
   EKG on admission indicated acute myocardial infarction and left atrial overload.
   Patient's diagnosis was Cardiogenic Shock due to Acute Myocardial Infarction; Bilateral pleural effusion; left lower lobe opacity highly suggestive of malignancy (which was not proven during admission); Cardiac Arrthymias; Frequent Premature Ventricular Contractions and Ventricular Tachycardia.

Of note also cardiac profile on admission, SGOT, LDH, and CPK were elevated on admission and continued to elevate up until date of death with CPK rising to 1,805 indicating massive myocardial damage the day prior to death.

ENVIRONMENTAL INFLUENCE

Patient account [redacted] Another case which indicates outside influences on mortality is the case of a 61 year old admitted to the hospital in Hepatic failure and discharged with Hepatic Encephalopathy. Patient had history of heavy alcohol abuse and cirrhosis of the liver. Patient was admitted with severe hypokalemia and hyponatremia. Family members refused nursing home care and patient was discharged to family care after meeting appropriate discharge screens. Patient expired 10 days after discharge.

Patient Account [redacted] 91 year old admitted from family home with large gangrenous infected decubitus ulcers, dehydration, and malnutrition. Ulcers were surgical debridement with osteotomy of multiple ulcers involving sacrum and both hips. Patient continued to deteroriate and expired 10 days after admission.

Oak Cliff Medical and Surgical Hospital strives to offer all patients the highest quality of care. Our hospital is in an area of Dallas that is heavily populated with the elderly.

We feel when reporting Mortality data to the public that the entire picture should be reflected. I understand that this is difficult to do with the sheer volume with which you have to work.
Lastly, I certainly appreciate advance notice so that we can analyze and clarify those circumstances which are not altogether clear.

Sincerely,

Donn C. Baker
Managing Director

cc: Universal Health Services
Steve Volla
Universal Corporate Center
367 S. Gulph Road
King of Prussia, PA. 19406

TX 354.2

AMI Odessa Women's and Children's Hospital

Medicare Provider # 450661

October 15, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Mortality Statistics - 1986

Dear Administrator:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for the year 1986. Since receiving the report dated September 1, 1987, Odessa Women's and Children's Hospital staff has had an opportunity to review the data.

The Medical Staff at Odessa Women's and Children's Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Medical Staff sections, and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital.

The Director of QA has validated that the data is correct. All cases in this report have been reviewed with the physician chairman of the Utilization Review Committee.

The following summarizes our findings by major diagnostic category:

Pulmonary Disease: Predicted: 7-29% Ours: 6%

- The number of deaths is this category reflect one of the intense services at our facility - Adult Special Care Unit.
- All patients had chronic and progressive pulmonary disease.
- The families of two of the patients had requested no further use of ventilatory assistance via a ventilator. The other patient expired 14 days after discharge.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Renal Disease: Predicted: 2-82% Ours: 67%

- This represents 2 deaths out of only 3 patients admitted in this category.

- One of the patients was also a previously diagnosed terminally ill cancer patient.

Sepsis: Predicted 3-91% Ours: 50%

- This represents one death.

- The patient suffered 2 cardiac-respiratory arrests, the last having an unsuccessful resuscitative outcome.

Other Diagnosis:

- Family requested no further ventilatory assistance for 1 of the patients.

Again, thank you for the opportunity to present this response. If you or anyone receiving this information has additional questions, please do not hesitate to call.

Sincerely,

T. D. Shapiro
Executive Director

TDS/adb/db4:043

TX 356.1

GATEWAY MEDICAL SYSTEMS

Omni Hospital & Medical Center

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D. C. 20201

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for October 1, 1984 through September 30, 1987. Since receiving the report, Omni Hospital & Medical Center has had an opportunity to review the data.

Our hospital Medical Staff Committees monitor every death in our facility on an ongoing basis. We believe that our monitoring system provides us with a continuous feedback mechanism, in an effort to continue to meet and exceed quality care standards.

This release is by Diagnosis Related Grouping, in which we fall between predicted ranges. As previously stated, review by this facility is always by individual case, re: overall quality of care, and is conducted in an on-going fashion, not just when statistics, such as the mortality date, are released.

The Medical Staff of Omni Hospital, as has been their practice, will continue to review all mortality causes for quality and appropriateness of care rendered to the individual patient. Trending analysis from these reviews is a constant endeavor to assist in identifying opportunities to improve care.

Thank you for the opportunity to present this response.

Sincerely,

James M Outlaw

James M. Outlaw
Administrator

JMO:llf

P.O. BOX 23308 • HOUSTON, TEXAS 77028 • (713)631-1550

September 25, 1987

ORANGE
MEMORIAL
HOSPITAL

Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Re: Hospital Mortality Information
Provider #

Dear Sirs:



I am in receipt of the report of the mortality rate for the above hospital. My staff and I have reviewed it and have no general comments.

Our records do reflect the following errors in dates on your report.

Pt. I.D. No.	Name	Correct Date of Admission	Discharge	Death
[redacted]		3-04-86	3-04-86	3-04-86
		7-30-86	8-03-86	8-03-86
		6-28-86	6-28-86	6-28-86

We realize these corrected dates have no impact on the report and are simply called to your attention.

Sincerely,

James E. Berry,
Administrator

JEB/cc

608 Strickland Drive • Orange, Texas 77630 • 409/883-9361

AMI Park Place Hospital

October 19, 1987

Dr. William Roper, Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper:

Thank you for the opportunity to provide input on the 1986 HCFA mortality statistics for AMI Park Place Hospital.

We were pleased to note that in spite of the increasing numbers of acutely-ill patients we treat and in spite of the increasing severity of their illnesses, your data shows our Hospital to be well within the expected mortality ranges for all 16 disease categories of your study. This information supports our belief that the care provided by Park Place Hospital and the physicians who practice here is of the highest quality.

The Hospital's ongoing Quality Assurance Program includes a detailed review of each patient's hospitalization. This review is under the direction of the Medical Staff and corrective action is taken when necessary to insure ongoing quality and effectiveness of all hospital and physician services.

The effectiveness of this Quality Assurance Program is partly responsible for Park Place Hospital receiving full accreditation by the Joint Commission on Accreditation of Healthcare Organizations.

Park Place Hospital is a 223 bed full-service medical center offering care in specialty areas of oncology, radiation therapy, major orthopedic services, rehabilitative services, as well as general medicine and surgery. Because of the specialty nature of many of our services, we conducted a verification of the statistics provided by HCFA. Except for a few minor discrepancies, it was determined that the data was reasonably correct.

Again, thank you for providing information which gave us an additional way to review the care we provide to the people of Southeast Texas. Our goal continues to be providing the highest-quality medical care available in the area.

Sincerely,

Luis G. Silva
Executive Director

LGS/blp

[illegible]

PARKLAND MEMORIAL HOSPITAL
DALLAS COUNTY HOSPITAL DISTRICT
5201 HARRY HINES BOULEVARD
DALLAS, TEXAS 75235
214 [illegible]-6011

COMMENTS ON THE HCFA MORTALITY DATA
Parkland Memorial Hospital, Dallas, Texas
(Hospital ID Number 450015)

Data Verification

The data used by HCFA indicate that a total of 286 Medicare patients admitted to Parkland Memorial Hospital died within 30 days of admission. Of these, HCFA reported that 202 died while still in the hospital, while 84 died after discharge. Our own recores indicate a major discrepancy in the number who died after discharge. From review of the medical records of the 84 patients indicated by HCFA to have died after discharge from the hospital, only 59 of them actually died after discharge, while 25 of them died while still in the hospital. This discrepancy suggests that the HCFA computer analysis failed to identify accurately the final admission for these patients. Because HCFA's definition of the period of followup does not coincide with our record-keeping system, it is impossible for us to verify the HCFA data further.

Results of Parkland's Concurrent Death Audit

Having long ago recognized the importance of reviewing inhospital deaths, Parkland Memorial Hospital has conducted a concurrent audit of all medical deaths since 1976, predating the HCFA initiative by 10 years. In this audit process, we have continuously monitored the quality of hospital care that might influence the risks of death in the hospital. In recent years the results of the audits have indicated a virtual absence of unanticipated deaths that might have been preventable, as judged by independent medical opinions. As a result, we were quite surprised to see that our mortality rates were judged by the HCFA analysis to be excessively high in three categories: genito-urinary (GU), sepsis (SE) and major trauma (TR).

To determine the reasons for these HCFA findings, we reviewed the medical records and the results of the concurrent death audits of the 41 deaths in these three categories (GU 17, SE 12 and TR 12). As will be apparent from the findings of our analysis, we found that all 41 deaths were either expected or unpreventable, thus indicating that HCFA's mortality prediction model substantially underestimated the predicted mortality rate to be expected in our hospital.

Specifically, our analysis found that the average age of the 41 patients was 77 years (with no significant difference among the three categories). The routine concurrent death audits found that the deaths of 88% of these 41 patients were anticipated at the time the patients were admitted to the hospital on the basis of the severity of their admitting illness (GU 82%, SE

92% and TR 92%). In 51% of these admissions (GU 77%, SE 33% and TR 0%), the physician had determined in consultation with the family and had documented on the medical record that the patient's condition was sufficiently terminal that no extraordinary resuscitation efforts should be made in case of death. In addition, 34% of the deaths occurred within the first 24 hours of admission and 42% within the first 72 hours (GU 24%, SE 67%, and TR 33%), indicating far advanced mortal illness at the time of admission.

A specific audit of the 12 deaths in major trauma found that 9 of the 12 deaths were in patients with severe burns, Parkland being a major burn treatment center. In all 9 burn cases, the percentage of the body surface area involved averaged 42% (range 25% to 89%). More importantly, since the probability of survival is accurately predicted by the combination of the patient's age and percentage body burned, all of these burned patients had greater than a 100% likelihood of dying. Besides these burned patients, two patients died of massive injuries sustained in motor vehicle accidents considered to be fatal at the time of admission, and the last patient was an 81 year old woman with severe senile dementia treated in the hospital for a hip fracture who died in a nursing home 8 days after discharge.

When these concurrently measured prognostic factors were analyzed simultaneously, we found that all but 4 deaths were either expected on admission, considered by the physician and family to be terminal (not to be resuscitated), died within 72 hours of admission, or considered to have a 100% fatal burn. The 4 who were not predicted by these concurrent criteria included the following:

1. An 80 year old man with stage D (disseminated) pancreatic cancer and widespread tuberculosis who died of a massive gastrointestinal hemorrhage.

2. A 79 year old woman with renal failure from a colovesical fistula from diverticulosis who suffered cardiac arrest during emergency renal dialysis.

3. The 81 year old woman with the hip fracture described above.

4. A 54 year old man who died of complications of a renal transplant.

The final assessments from the concurrent death audits found that 90% of these 41 deaths were anticipated and considered unpreventable by the medical team, 10% were unanticipated but considered unpreventable, and none was considered preventable by the peer review.

Conclusions

These findings indicate that the deaths that occurred in Medicare patients in the three diagnostic categories--genito-urinary, sepsis and major trauma--in 1986 did not constitute an excessive mortality rate. On the contrary, all were determined by a long established peer review system to have been unpreventable. This indicates that the HCFA model seriously underestimated the expected mortality risk of our patients in these categories. From examination of the HCFA mortality prediction model, it

appears clear that the reason for this underestimate is the failure of the HCFA prediction model to account for the probability of death on admission, an essential parameter that is not captured by any of the variables used in the HCFA model nor by any information presently collected in any HCFA data base. While Parkland Hospital has been a leading advocate of the need for continuous concurrent mortality review as an essential part of an effective quality assurance program, our analysis indicates that HCFA's retrospective approach to mortality review is invalid and ineffective. We recommend that until reasonable scientific studies confirm the validity of retrospective prediction models using Medicare case reporting data, HCFA discontinue the reporting of observed and predicted mortality rates and, instead, recommend that all hospitals audit deaths concurrently as we have effectively done.

Pasadena General Hospital

October 20, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

After analyzing your published mortality data the following observations are made concerning Pasadena General Hospital.

1. Our overall mortality rate is well within the predicted range for the acuity mix for our hospital.

2. The breakout reveals that of the fourteen categories studied Pasadena General ranked in the lower fifty percentile in eleven of those categories. We ranked in the seventy-fifth percentile in one category.

3. We exceeded the 91 percent predicted range in one category, in which we only had two patients who both expired after admission. Both patients were emergency admissions, with multiple diagnosis complicating the primary reason for admission.

The only inaccuracy noted in the data was regarding patient ID number (HIC) [redacted]

Published Date Of Discharge	Published Date of Death	Actual Date of Death
10/9/86	10/16/86	10/9/86

We appreciate the opportunity to respond to your data prior to publication.

Sincerely,

Elizabeth A. Primeaux
Acting Administrator

EAP:sh

Hospital ID# 450197

1004 SEYMOUR, PASADENA, TEXAS 77506 (713) 473-1771
AN AMERICAN HEALTHCARE MANAGEMENT, INC. HOSPITAL

Physicians & Surgeons Hospital

3201 Sage Street
Midland, TX 79705
915/683-2273

October 12, 1987

Richard Husk
HCFA
Health Standards Quality Bureau Office of Medical Review
Meadows East Building
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Mr. Husk:

The data used by HCFA indicated that a total of (17) seventeen Medicare patients admitted to Physicians & Surgeons Hospital died within 30 days of admission. Of these, (15) fifteen died while still a patient of the hospital, while (2) two died after discharge. Our own records indicate that 497 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at Physicians & Surgeons Hospital is correct. Our own records also indicate that of the (17) seventeen Medicare patients who died within 30 days of admission while still an inpatient, (2) two patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Sincerely,

Richard C. Liley
Executive Director

RCL/lj

October 28, 1987



William L. Roper, M. D., Administrator
Department of Health & Human Services
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
Post Office Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Polly Ryon Memorial Hospital is a 149-bed, general acute hospital serving a population base of approximately 40,000 persons (approximately 50% of the hospital census is composed of Medicare patients). It is important to note that the community we serve includes six nursing homes with a total of 537 beds. It is estimated that as many as one-third of the residents of these nursing homes are originally out-of-county residents from metropolitan and suburban Houston, Texas. Therefore, the crude data reflected in the 1987 HCFA Mortality Statistics is at least at first glance, initially, not necessarily reflective of the immediate Richmond/Rosenberg population.

Representatives of both the hospital Administration and medical staff participated in the HCFA Mortality Review. The review included examination of all 126 patient charts for appropriateness of diagnostic and therapeutic management in both past and terminal admissions.

The review revealed a variety of significant findings. Of the 126 Medicare deaths recorded in the institution, the average age of the patient group was 79. Greater than 50% of all patients who expired were admitted through the Emergency Room, indicating acuteness of medical condition and potential extreme severity, as well. Greater than 90% of all 126 patients who expired were "no codes" with multiple medical diseases. In addition, the no code status designated for this group of patients was one requested, and therefore, probably accepted by the family concerned.

After the review of the mortality data provided by HCFA, the medical staff and hospital Administration will have a large bank of information by which to better serve the community. Obviously, cerebrovascular disease will be a targeted area of significant interest for improvement of both hospital and medical staff services. It is important to note, however, that already this disease category has been the subject of an extreme amount of attention by a number of attempts to effect its optimal treatment. These specific attempts include increasing numbers of specialists admitted on the medical staff whose specific interests include cerebrovascular diseases, the purchase of radiologic equipment to better assist our radiologists in the evaluation of this group of disorders, the initiation of discussions to establish stroke support groups through the American Heart Association, and initiation of provision of additional surgical services for prophylactic therapy of at-risk patients.

1705 Jackson Street
Richmond Texas 77469
713/342-2811

We wish to remind you that the medical staff, on an on-going basis, monitors every death in our facility through numerous committees, including OB/Nursery Committee, Surgery Committee, Morbidity/Mortality Committee, and Quality Assurance Committee. The assurance of excellent peer review in our institution has been validated by the bestowing of a three-year period of accreditation by the Joint Commission on Accreditation of Hospitals at the time of its last visit. Finally, all medical staff members, with the aid of the Governing Board and hospital Administration, will continue trending analyses of all patient deaths in a constant endeavor to assist in identifying any opportunity to improve patient care.

Sincerely,

S E Thompson, MD

Stanley E. Thompson, M. D., Chief of Staff

Harold F. Taylor, Administrator

L. R. Reveley, M. D.

Louis R. Reveley, M. D., Chairman
Morbidity/Mortality Committee

LRR/vyd

Medicare Provider No. 450330

TX 376.1

Presbyterian
Healthcare System

8220 Walnut Hill Lane
Suite 700
Dallas, Texas 75231
(214) 696-8501

Douglas D. Hawthorne
President
Chief Executive Officer

October 26, 1987

William L. Roper, M.D.
Administrator,
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics which will be published in December. This information has been reviewed by representatives from the Medical Staff, Administration, Medical Records, and Quality Assurance. While we feel there has been a big improvement from last year, we continue to have reservations with the methodology used by HCFA in analyzing these statistics. Additionally, we have some concerns about the accuracy of the data, particularly the information relating to out-of-hospital deaths.

Presbyterian Hospital of Dallas is an 838 bed facility caring for patients with a wide variety of medical and surgical illnesses. Patients are referred from throughout the Dallas/Fort Worth metroplex and northeast Texas. In addition to our general medical and surgical services, we have programs in cardiology, oncology, dialysis, rehabilitation, neurology/neuro-surgery, orthopedics, and gynecology. Since we are a referral hospital, we do care for the most acutely and chronically ill patients. Therefore, it would not be unexpected to have a higher mortality rate than institutional providers who have a less complicated mix of cases.

We do not feel that the statistics presented adequately take into consideration severity of illness. Of the patients listed for Presbyterian Hospital of Dallas, over 70% had at least one complicating factor and over 40% had multiple complicating factors.

As a hospital providing care to a wide range of patients, we are also concerned with the use of mortality statistics to infer the measurement of quality of care. We believe that all would agree that quality must be judged by a combination of factors, not simply the review of one factor. At Presbyterian Hospital of

Dallas, our medical staff reviews mortalities as part of our overall hospital quality assurance program. This program monitors many other factors that provide continuous feedback on the care provided. We feel strongly that Presbyterian Hospital of Dallas provides quality care to all of our patients.

Again, thank you for the opportunity to respond to the mortality statistics.

Sincerely,

Douglas D. Hawthorne
President

Presbyterian Hospital of Winnsboro
A Member of the Presbyterian Healthcare System

PROVIDER NUMBER 450224

719 West Coke Road
P.O. Box 106
Winnsboro, Texas 75494
(214) 342-5227

October 19, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

The data used by HCFA indicate that a total of 51 Medicare patients admitted to Presbyterian Hospital of Winnsboro died within 30 days of admission. Of these, 36 died while still a patient of the hospital, and 15 died after discharge. Our own records indicate that 472 Medicare admissions occurred in 1986; the figure HCFA used was 285. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Utilizing the total number of Medicare admissions from our records, our mortality rate would be 7.8% rather than the 18% suggested by HCFA. Mortality rate per each of the diagnostic categories would also be lower. It is impossible to determine the percentage of the 14 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

In none of the diagnostic categories does our hospital's actual mortality rate fall outside of the range of predicted mortality rate.

Of the 51 deaths attributed to our hospital, at least half had more than one medical problem attributing to their death which is empasized by the fact that the average age of all deaths of our patients within the hospital was 83 years. We feel it significant to also comment that 10 of the 14 deaths that occurred outside the hospital were nursing home patients.

Our local community does not have skilled beds available; therefore, many of our Medicare admissions are due to end-stage diseases admitted from the nursing homes to our hospital rather than while under care for an acute condition. Our hospital's average daily census for 1986 consisted of 78% Medicare patients.

Our Medical Staff consistently reviews all deaths for quality assurance and we do not feel that the quality of care issue should be confused or allowed to be interpreted by a meaningless mortality rate prediction.

Thank you for allowing hospitals to comment on the statistical information to be published.

Sincerely,

Jerry Hopper
Executive Director

JH/mb

Enclosure

PRESBYTERIAN HOSPITAL OF WINNSBORO
PROVIDER NUMBER 450224

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	6	1	6	1
CE -- Cerebrovascular Accidents	2	0	2	0
GC -- Gastrointestinal Catastrophes	1	0	1	0
GI -- Gastrointestinal Disease	0	1	1	0
GU -- Urologic Disease	2	2	2	2
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	0	1	0	1
HM -- Severe Chronic Heart Disease	2	2	2	2
HS -- Severe Acute Heart Disease	11	0	11	0
ME -- Metabolic/Electrolyte Disturbances	1	1	1	1
OP -- Orthopedic Disorders	0	1	0	1
PN -- Pulmonary Disease	9	3	9	3
RN -- Renal Disease	0	0	0	0
SE -- Sepsis	1	0	1	0
TR -- Severe Trauma	0	0	0	0
OP -- Ophthalmalogic Disease	0	0	0	0
UN -- Other Diagnoses	1	3	1	3
Total -- All Categories	36	15	37	14*

*Deaths outside the hospital were not verified.

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

TX 378.1

PROVIDENCE HOSPITAL

1700 Providence Drive • P.O. Box 2589 • Waco, Texas 76702-2589 • 817-753-4551

October 22, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
6325 Security Blvd.
Baltimore, MD 21207

RE: 45-0042

Dear Dr. Roper:

Thank you for the opportunity of responding to the release of data on Medicare mortality rates for 1986. This response comes after a review of the data by members of the hospital staff and Medical Staff.

Providence Hospital is a 260-bed general, acute care facility serving the citizens of Central Texas. The hospital receives patients from other hospitals throughout the region for a wide variety of illnesses. Providence provides specialty care in the areas of cardiology, open-heart surgery, gastroenterology, psychiatry and respiratory care as well as general medicine and surgery.

The statistical model used by the Health Care Financing Administration attempts to assess the hospital's quality of care from mortality data. Even though various factors such as age, sex, and pre-existing conditions were used to predict death rates in certain diagnostic categories, the reliability of the numbers in making a definitive judgment about quality of performance is questionable. The statistical model does not completely account for the patients' severity of illness, which is a key determinant in death rates. Also, it is difficult to assess an institution's quality based on mortality data only. Therefore, we believe the public should view the statistics as a benchmark and not an absolute measure of quality.

Each and every mortality at Providence Hospital is thoroughly reviewed by members of the Medical Staff with respect to medical management and overall care. Mortality review is a component of the overall quality assurance function which is performed by physicians, using specific standards of practice for each medical specialty. The Quality Assurance Program encompasses every aspect of hospital services with the goal of providing optimal achievable care.

The mortality data released by HCFA contains the total mortality rate for Medicare patients and for 16 diagnostic categories of Medicare patients. In every area the actual rate for Providence Hospital fell within the range of predicted rates. The mortality information uses hospital-specific data; therefore, mortality rates for different institutions cannot be compared. Additionally, since the data reflects some deaths that occurred after discharge, it is difficult to completely verify the accuracy of the data. The public should keep this in mind when they review the information.

Consumers are taking a more active role in decisions regarding their health care. While we agree that education is a key factor in increased awareness, it is important not to draw final and potentially inaccurate conclusions from raw figures.

HCFA has made noticeable progress over the past year in attempting to develop its statistical model for assessing mortality data. We hope future efforts will ultimately produce a more reliable measure of quality of care.

Again, thank you for this opportunity to respond.

Sincerely,

Kent A. Keahey, FACHE
President

Providence Memorial Hospital 2001 N. Oregon • El Paso, Texas 79902 • 915/542-6011

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Providence Memorial Hospital's Medical Staff Quality Assurance Committee and our Quality Assurance Department have reviewed the mortality data provided by HCFA.

It was gratifying to note that Providence fell well within the HCFA expected range of mortality in all diagnostic categories. We are well aware, however, that mortality data is only one indicator of hospital quality, and Providence is continuing to make a strong, ongoing effort to evaluate our care in many ways.

The Medicare population of our community is a substantial segment of the patients served at Providence. As might be expected, the age of our medicare patients and the severity of their medical problems, when admitted to the hospital, has shown an increasing trend.

The following comments from our review will be of interest to HCFA and other interested persons.

In the diagnosis category, "Metabolic/Electrolyte Disturbances" which includes diagnosis such as diabetes and dehydration, our hospital was within the expected mortality norms in this and all other categories. It should be noted that the average age of individuals that expired in this category was 85 and all had other significant medical problems.

In the diagnostic category, "Pulmonary Disease", we have a question regarding the mathematics. The HCFA study shows 30 deaths in 173 cases at Providence. If this is correct, the mortality rate should be 17.3%, not the 23% shown in the report. In 63% of the cases reviewed, physicians and families had requested extraordinary life support measures not be used, due to the advanced condition of the illness of these patients. The patients who expired had been admitted with multiple health problems such as terminal cancer, and their average age was 83.

In the diagnosis category "Sepsis" which involves an infection of the blood, 64% of the cases listed by HCFA, physicians and families asked that extraordinary life support measures not be used. Three of the 14 patients in this category had terminal cancer as well as sepsis.

Providence is El Paso's only full-service acute care not-for-profit hospital. We provide a complete range of medical care such as our cancer unit, a fully accredited program, as well as cardiovascular, pulmonary, and rehabilitation services. Our efforts have been recognized by the Joint Commission on Hospital Accreditation.

Our commitment at Providence is to excellence in healthcare. Objective analysis of mortality data has long been one of our quality criteria, and as an affiliated member of the Voluntary Hospitals of America, we are part of a nationwide program monitoring quality.

We are confident HCFA and the community we serve, will continue to see positive results from our efforts in the future.

Sincerely,

Robert I. Richardson
Executive Vice President

James Sabal, M.D.
James Sabal, M.D.
Chief of Staff

RIR:JS:sah

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

R. E. Thomason General Hospital in El Paso, Texas would appreciate the addition of the following information to the Hospital Specific Mortality Report prior to its publication. The attached list is a list of discrepancies found in the data we received.

R. E. Thomason Hospital is a 365-bed, Joint Commission accredited acute care public hospital whose patient population includes a large number of indigent patients with major medical and surgical illnesses. The Hospital is located three miles from the Mexican border, and is affiliated with the Texas Tech University School of Medicine.

The entire spectrum of health care of each patient is monitored and evaluated in each clinical department utilizing professional peer review standards. This review includes all patients who expire at the Hospital as well as a detailed analysis of cardiac arrest procedures - and is an ongoing part of the quality review process, conducted by both medical and hospital staff.

The hospital-specific mortality data generated by the Health Care Financing Administration has been carefully evaluated by Hospital Administration, Medical Staff, Utilization Management, and Quality Assurance. This data, though reflective of the Medicare portion of our patient population, provides us with an additional opportunity for review of the processes and outcomes of this group.

This year's refined statistical model, using predicted rates and ranges that are hospital specific, is an improved technique. We agree that such data is useful, but do anticipate that severity of illness measures will be applied to the data in the future methodology.

Quality of service review is generated on every patient admission, not just upon outcome of death or production of statistical data. It is this

R.E. General Thomason Hospital • 4815 Alameda Avenue • P.O. Box 20009 • El Paso, Texas 79998 - 0009 • 915/544-1200

Affiliated with Texas Tech University School of Medicine

team approach to patient safety that provides R. E. Thomason Hospital with a continuous feedback mechanism for assuring the most positive outcome possible for its patients.

Thank you for this opportunity to preview and comment on the hospital specific mortality information generated for 1986 by the Health Care Financing Administration.

Sincerely,

Bill Kennedy
Executive Director

BK:bl

attachment

R.E. Thomason General Hospital
El Paso, Texas

HIC No.	Patient	Correct Date of Death
[redacted]	[redacted]	12/20/86
[redacted]	[redacted]	1/22/86
[redacted]	[redacted]	12/23/86
[redacted]	[redacted]	6/22/86
[redacted]	[redacted]	12/12/86
[redacted]	[redacted]	6/16/86
[redacted]	[redacted]	11/27/86

Ranger General Hospital
Hwy. 80 West — Phone 647-1156
RANGER, TEXAS 76470

October 9, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Thank you for the information we received concerning the mortality rates and statistics for Ranger General. We wish to comment concerning this report, especially with regard to the stats on severe acute heart disease. We noted that all 9 patients that were included in this report had ages that averaged 80 years old. All of these patients had multiple system diseases in addition to the acute heart disease.

Most of our patients are elderly since we are located in a retirement community, and we feel that if there does appear to be an increase in mortality rate for our hospital, this is more cause than anything else. These patients are most times chronically ill and have been sent to our hospital from larger facilities to be closer to their families during their "last days".

We would appreciate the consideration of this information in relation to the mortality information to be released for publication for our hospital.

Sincerely,

Bill Johnson, Administrator
Ranger General Hospital

BJ/ds



805 NORTH MAIN AVE. Reagan Memorial Hospital BIG LAKE, TEXAS

September 25, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore, Maryland 21207

RE: Provider #45-0607

Dear Sirs:

In response to the mortality information soon to be released concerning Reagan Memorial Hospital, Big Lake, Texas, I offer the following comments.

1. Patient ID [redacted] This patient is listed in Diagnostic Category HS. After review of coding by our PRO, the Texas Medical Foundation, this patient should be under category CE. With only one patient under HS this places the actual mortality rate at 100% which is totally misleading, giving an untrue public perception. In addition, with the condition of the patient upon arrival at the emergency room, the patient might easily have expired before ever being admitted as an inpatient.
2. Patient ID [redacted] This patient was transferred in from the nursing home in critical condition and 5 hours later expired. Considering the condition of the patient upon admission, please consider the patient could easily have been admitted to observation and would never have shown up on statistics. This patient had a poor medical history.
3. Patient ID [redacted] This patient was also admitted from the nursing home with a poor medical history. The patient expired 11 hours later. Likewise, the patient could have been admitted as an observation patient.

My main point is this: The public will look at the percentages without considering the number of cases involved. These percentages will be considered and construed as the quality of care. I believe a small hospital, with few admissions, is at a disadvantage because of the volume of patients served.

Respectfully submitted,

Ron Galloway
Administrator

RG:po

Richardson Medical Center
401 West Campbell Road
Richardson, TX 75080
214/231-1441

October 27, 1987

Harvey Brook
Health Care Financing Administration
Meadows East Building
Room 2 D 2
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Mr. Brook:

Richardson Medical Center is writing in response to your communication regarding the public release of hospital data. We welcome this opportunity to respond and would like to request that this information be included with Richardson Medical Center's data prior to public disclosure.

Richardson Medical Center is a 239 bed acute care facility, whose case mix includes varied medical and surgical illnesses. We are considered a full service hospital and are equipped and staffed to offer such specialty areas as intensive care, pulmonary medicine, neurosurgery and orthopedic surgery.

The Director of Medical Records has verified that RMC's specific mortality data for Medicare patients reported by HCFA is accurate, with minor exceptions. This information has been reviewed by members of the Board, Administration, and Medical Staff. RMC's Medical Staff Departments review, on a monthly basis, the medical record of each patient who expires at our facility. As a facility approved by the Joint Commission on Accreditation of Hospitals (JCAH), we maintain on-going Quality Assurance and Peer Review activities that monitor standards of appropriateness and quality of care in our healthcare system.

RMC's percentage of deaths for Medicare patients in the categories identified by HCFA fall well within the predicted ranges set by the HCFA model for our hospital. We feel the following notations will supplement any interpretation of RMC data.

* The actual cause of death for a large percentage of the cases did not match the data supplied by HCFA. The use of "principal diagnosis," as listed for for admission purposes, did not always correspond to the actual cause of death for many patients.

* Most importantly the model fails to recognize and provide for the severity of a patient's illnesses. While comorbidity factors of death are recognized in the HCFA model, there is no mechanism provided to assess the weight of these contributing causes of death.

Additional information may be obtained by contacting RMC's Administration office at (214) 680-4700.

Sincerely,

H. Kenneth May, FACHE
President
Richardson Medical Center

HKM/cb

RHD MEMORIAL
MEDICAL CENTER

October 26, 1987

HCFA
Department of Health & Human Services
Att'n: HSQ-148--GNC
P.O. Box 26676
Baltimore, Maryland 21201

Re: Mortality Statistics
January 1, 1986 - December 31, 1986

Dear Sir:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for calendar year 1986. Since receiving our Hospital Specific report dated September 21, 1987, RHD Memorial Medical Center staff has had an opportunity to review the data.

RHD Memorial Medical Center is a 323 bed healthcare facility comprised of a 190 bed acute care hospital and a 133 bed psychiatric hospital. The mortality data relates exclusively to the acute care hospital, a full service major medical and surgical facility. RHD Memorial is a full service acute care hospital offering care in specialty areas of oncology, open-heart surgery, extensive cardiology diagnostic services, major orthopedic services, as well as general medicine and surgery.

The Medical Staff at RHD Memorial Medical Center through the appropriate medical/surgical physician clinical department conducts an on-going review of every mortality in our facility for appropriateness of care. In specific reference to the 123 cases listed by HCFA as 1986 Mortality cases for RHD Memorial, our Director of Medical Records has validated that, with minor exceptions, the data is accurate. In addition, our Director of Quality Assurance has reviewed all cases reflected in this report. Based upon this comprehensive review of this data and the specific medical records it reflects, we are confident that you and members of the public who request a copy of our statisfical information will be interested in the following summary report.

In summary, the actual mortality rate specific to RHD Memorial Medical Center for all causes and by diagnostic category reflects actual rates within the "range of predicted mortality rates." As reflected by RHD Memorial's relatively higher range of predicted mortality rates, the Medical Center's case mix does reflect a higher severity index due to the facilities concentration of services in cancer and cardiac care. In addition, the Hospital serves as the acute referral facility for three area extended care nursing facilities (total beds 589) as well as participating with an in-patient Hospice program. While the HCFA report reflects 808 total medicare admissions with an actual mortality rate of 15% for a predicted range of 9 to 17%, the Hospital records reflect a medicare admission figure of 1257 (without elimination of multiple admissions during 1986) with a resulting actual mortality rate of 9.8%. A review of the following six diagnostic categories included in the 1986 Mortality Report reflects support for this summary and the detail findings that follow:

CA CANCER

- 37% actual mortality - predicted mortality range 18-47%

Sixteen of forty-three cases were identified as deaths occurring within 30 days of admission. Fourteen of the sixteen cases had "Do Not Resuscitate" orders prior to expiration. Six of those cases were admitted to the hospice program. Three deaths occurred after discharge and these were patients discharged to hospice. Of the identified cases, 87% had prior history of cancer and had been receiving chemotherapy and/or radiation treatment and were admitted with complications resulting from the cancer.

EY OPTHALMOLOGIC DISEASE

- 25% actual mortality - predicted mortality range 0-100%

Of 4 cases in this category, one was identified by HCFA as a death occurring within 30 days of admission. However, upon analysis, this patient was admitted 6/23/86 with pneumonia and congestive heart failure and expired in the hospital on 7/1/86. Further, it was noted that the patient had been in the hospital 6/16/86 through Day Surgery and had bilateral cataract surgery performed without complications and discharged same date. Thus, this case should not be reported in this category and should also reflect 0% actual mortality rate rather than 25% as shown.

GC GASTROINTESTINAL CATASTROPHIES

- 38% actual mortality - predicted mortality range 4-48%

There were 5 cases of the 13 reported that expired within 30 days of admission. Four of the five cases identified had "Do Not Resuscitate" orders prior to expiration. All cases had a history of multiple comorbidities prior to admission.

HM SEVERE CHRONIC HEART DISEASE

- 29% actual mortality - predicted mortality range 12-39%

Of the 38 cases reported, 11 were identified as deaths within 30 days of admission. Ten of the cases had a prior history of arteriosclerotic heart disease, congestvie heart failure and other comorbidities. Five of the cases had "Do Not Resuscitate" orders prior to expiration and six expired post cardiopulmonary resuscitation as a result of congestive heart failure. On nine cases, the cause of death was listed as congestive heart failure. The average age of the 11 cases was 79. Five of the admissions came from the Emergency Department and five came direct from Nursing Homes in the area.

PN PULMONARY DISEASE

- 28% actual mortality - predicted mortality range 11-30%

Of the 75 cases reported, 21 were identified as deaths within 30 days of admission. All cases identified had a history of chronic obstructive pulmonary disease with components of emphysema, asthma and bronchitis. All cases were admitted with pneumonia exacerbated by components of chronic obstructive pulmonary disease. Sixteen of the cases had "Do Not Resuscitate" orders prior to admission or before expiration. Ten cases came through the Emergency Department and were transferred from Nursing Homes in the area. The average age of these cases was 81.

Again, thank you for the opportunity to clarify the mortality data.

Sincerely,

James R. Shafer
Executive Director

/rc

TX 392.2

October 26, 1987

ROSEWOOD
MEDICAL
CENTER

William L. Roper, M.D.
Administrator, HCFA
Dept. of Health and Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:



Rosewood Medical Center has analyzed the HCFA data received 9-21-87 and has drafted the following response for public disclosure in December:

Rosewood Medical Center is a 235 bed acute care facility whose case mix includes patients with medical and surgical illnesses and offers care in specialty areas of oncology, pulmonary medicine obstetrics, gynecology, orthopedics, psychiatry, rehabilitation medicine as well as general medicine and surgery.

The hospital specific mortality data received from the Health Care Financing Administration (HCFA) has been reviewed by Rosewood Medical Center's President of the Medical Staff, Chairman of the Utilization Review Committee, Chairman of the Medical Care Appraisal Committee, Chief Executive Officer, and Directors of Utilization Management and Medical Records.

The mortality rates are not necessarily an indicator of quality either high or low. It is necessary to evaluate more than number or percentages of deaths in order to evaluate whether a patient was given the best available care. This is accomplished by ongoing review of all medical management to study outcome and quality whether the patient lived or died. Factors which should also be relevant in evaluating quality are the patient's overall condition (his primary disease as well as chronic diseases which may contribute to his risk), the patient or family's wishes as to whether life sustaining measures should be started or stopped and severity of the patient's illness. Mortality review is only one indicator in a long list of criteria which merit review in Rosewood's quality assurance program and peer review activities.

9200 Westheimer • Houston, Texas 77063 • 713/780-7900

The records of all patients who expired within 30 days of admission were reviewed

a) for accuracy of HCFA data
b) to evaluate that the patient and family were given adequate care and support both in the hospital and post-discharge (where applicable)

For the most part, HCFA's data was found to be correct. Minor errors in dates of hospitalization and/or dates of death were found. But the listed patients still expired within 30 days of the final hospital admission. Categories where the mortality rate was noted to be on the high side of expected were not unusual due to the speciality areas which this facility treats (i.e. pulmonary medicine and cancer).

Statistical analysis revealed the average age of these patients was 79 years. In over 50% of the cases, the family or patient requested no extraordinary life sustaining measures in their medical care since their condition was terminal. Medical care was given to keep the patient comfortable in accordance with these wishes. In 90% of the cases, the patient had significant underlying diseases which contributed to death. The patients exhibited chronic conditions such as previous heart attacks with continuing heart problems, previous strokes, debilitating lung disease (such as emphysema), and cancer.

Severity of illness is very difficult to evaluate statistically. Some indicators of how severly ill the patient was were calculated with the following:

56% of patients were admitted through the Emergency Room
40% of patients were treated in Intensive Care Unit
32% of patients were previously residents of a Nursing Home
50% of patients expiring in the hospital requested not to be placed on machinery to sustain life
58% of the patients discharged were sent to a Skilled/Intermediate Care Nursing Facility

Rosewood places emphasis on assuring that patients receive adequate discharge planning. Evaluation showed that all patients who were discharged form Rosewood were offered assistance in post-discharge planning. These consisted of skilled or intermediate nursing home placement, home health nurses, Hospice for cancer patients along with follow-up by their own physician. It was noted that 73% of patients received discharge planning assistance while 22% expired within 24 hours precluding discharge planning. It was noted that the remainder of patients not requiring discharge planning did have a follow-up visit scheduled with their own physician.

The records of all patients who expired within 30 days of admission were reviewed

a) for accuracy of HCFA data
b) to evaluate that the patient and family were given adequate care and support both in the hospital and post-discharge (where applicable)

For the most part, HCFA's data was found to be correct. Minor errors in dates of hospitalization and/or dates of death were found. But the listed patients still expired within 30 days of the final hospital admission. Categories where the mortality rate was noted to be on the high side of expected were not unusual due to the speciality areas which this facility treats (i.e. pulmonary medicine and cancer).

Statistical analysis revealed the average age of these patients was 79 years. In over 50% of the cases, the family or patient requested no extraordinary life sustaining measures in their medical care since their condition was terminal. Medical care was given to keep the patient comfortable in accordance with these wishes. In 90% of the cases, the patient had significant underlying diseases which contributed to death. The patients exhibited chronic conditions such as previous heart attacks with continuing heart problems, previous strokes, debilitating lung disease (such as emphysema), and cancer.

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expired within 24 hours precluding discharge planning

Rosewood Medical Center continues to strive to meet its tradition of providing quality healthcare for the community it serves.

Thank you for allowing this opportunity to reply to HCFA's publication of data.

Sincerely,

Thomas M. McGowan, M.D.
President, Medical Staff

Rod Seidel,
Chief Executive Officer

TX 396.3

October 26, 1987

William L. Roper, M.D.
Administrator, HCFA
Dept. of Health and Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

ROSEWOOD
MEDICAL
CENTER

Rosewood Medical Center has analyzed the HCFA data received 9-21-87. The following minor errors in dates of hospitalization and/or dates of death were found:

HIC Number	Name	Date	Corrections
[redacted]		4-06-86 to 4-14-86	This patient was readmitted 4-24-86 and expired 4-29-86 in the hospital.
[redacted]		2-28-86 to 3-19-86	This patient was readmitted 3-19-86 and expired 3-25-86 in the hospital.
[redacted]		4-01-86 to 4-17-86	This patient was readmitted 4-20-86 and expired 4-24-86.
[redacted]		7-10-86 to 7-29-86	Date of Discharge should be 7-20-86. Patient expired in hospital.
[redacted]		7-08-86 to 7-09-86	Date of death should be 7-9-86. Patient expired in the hospital.

HEALTHCARE

If you need any additional information please call me at (713) 780-7900 ext. 374.

Sincerely,

Sharon Sullivan

Sharon Sullivan, RN
Director Utilization/Risk Management

SS/jw

AMI Round Rock Community Hospital

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

In response to the release of mortality data composed by the Health Care Financing Administration (HCFA), the following information has been prepared.

AMI Round Rock Hospital is a 75-bed acute care facility located approximately 20 miles north of Austin, Texas. The hospital, owned by American Medical International, contains a 24 hour physician-staffed emergency room, state-of-the-art surgical suites, an intensive and coronary care unit and many outpatient services such as home health care. Since its opening in 1983, hospital and medical staff have worked together to provide quality medical care for area residents.

The Director of Medical Records has verified that the mortality information prepared by HCFA for Round Rock Hospital is correct. HCFA data reports that Round Rock Hospital is 100% within the "predicted mortality range". This range is computed by HCFA using statistical methodology.

All information has been thoroughly reviewed by the Director of Medical Records, Director of Quality Assurance, hospital administrators and the Medical Executive Committee. As an important part of our quality assurance program, these same individuals continuously review the quality of care provided in our facility.

It is our mission to provide excellent medical care to all area residents. Quality assurance standards and procedures permit us to achieve this goal.

Thank you for this opportunity to respond.

Sincerely,

Scott D. Evans, FACHE
Executive Director

2400 Round Rock Avenue Round Rock, Texas [illegible]

AMI Round Rock Hospital

Medicare Provider Number- H O 450 718

TX 397.1

Sabine County Hospital

BOARD MEMBERS:

Ross Parker, Chairman
James Whitton
Jamie Payne
Robert Wagstaff
W. L. (Bill) Turner

P. O. Drawer W

Hemphill, Texas 75948

Phone: 409/787-3300

October 6, 1987

W.L. Roper M.D. Administrator
Department of Health and Human Services
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

RE: Your letter September 21, 1987, 1986 Medicare Mortality Provider #450700.

The attached comments are submitted per above reference letter. I hope that our comments are pertinent and useful in the review and evaluation of our Mortality Rate for 1986.

Thank you for the opportunity extended to this provider to provide comments. If you have questions or additional information is desired, please contact me.

Sincerely,

J.D. Miller Jr., FAAMA
Administrator

Attachment as stated.

Sabine County Hospital

P. O. Drawer W

Hemphill, Texas 75948

Phone: 409/787-3300

BOARD MEMBERS:

Ross Parker, Chairman
James Whitton
Jamie Payne
Robert Wagstaff
W. L. (Bill) Turner

SABINE COUNTY HOSPITAL COMMENTS
ON 1986 MEDICARE MORTALITY

Generally, nationwide, hospitals that routinely handle the more critically ill-patients would naturally be expected to have a higher mortality rate than a hospital that handles less sick patients.

Sabine County Hospital is located in Hemphill, Texas, Sabine County, Texas in what is commonly referred to as Deep East Texas. The Eastern County Line is the same as the Louisiana/Texas state border. According to the 1980 Census, more than 19% of the residents of Sabine County were over 65 years of age and it is noted that this is greater than either the Texas State or the U.S. National Average. The average for our 12 county Deep Texas Council Area is 12% and the Texas State Average is 9%. Over 50% of our utilization at Sabine County Hospital is Medicare.

It is further noted that Sabine County is a Senior Citizen Retirement Area. Toledo Bend Lake is located on the Eastern side of Sabine County, and that the high percentage of Senior Citizens would most certainly impact the Mortality Rate of citizens of this county.

It is noted that Sabine County Hospital participates in the Medicare Swing Bed Skilled Nursing Program. Most Nursing Homes in this area are not Medicare Certified and therefore cannot receive Medicare payment for providing Skilled Nursing Services to Medicare recipients. The fact that Sabine County Hospital participates in this Medicare Swing Bed Skilled Nursing Program increases the number of potentially high risk older Medicare patients and therefore Mortalities for Sabine County Hospital.

In 1986, several patients were returned to our community and were hospitalized at SCH; who had been treated at metropolitan specially hospitals, and told that there was nothing more that could be done for them. These patients were terminal and choose to return home to pass on as comfortably and peaceful as possible among friends and neighbors, and at home. Of course these patients increased our Mortality Rate.

It should also be noted that since the Medicare DRG program was implemented, along with the PRO of Texas Medical Foundation(TMF), the general trend for acute care hospital patients is that the patients are more seriously ill than in some past years. The Texas Medical Foundation(PRO) criteria for medical necessity and appropriateness of care for Medicare acute care inpatients is much stricter and more restrictive than criteria used prior to the PRO Program in Texas. To be a covered acute care admission by the Medicare Program, the patient must be receiving treatment and care that could not be given in any other setting, such as Doctor's office, outpatient, Home Health, Nursing Home or other.

This has resulted in our Medicare in-patients being more seriously ill and therefore greater risk to Mortality. In summary, fewer and more seriously ill potentially high risk Medicare recipients are being admitted for in-patient acute care which in itself increases the Mortality rate per admission of Medicare recipients.

The DHHS Mortality Rate Report itself indicates that of the 40 Sabine County Hospital Mortalities, 29 were in the high risk diagnoses category. This is a major factor to be considered with this report.

TX 399.1

SAINT JOSEPH HOSPITAL

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for providing the opportunity to respond to the HCFA Mortality Data Release. Saint Jcseph Hospital is a 475 bed general adult acute-care facility located in "downtown" Fort Worth, Texas. The hospital has established centers of excellence in oncology, ophthalmology, orthopedics, physical medicine and rehabilitation, hospice, and psychiatry. These centers attract referrals from throughout Tarrant County and are also supported by an active emergency services department.

Saint Joseph Hospital recognizes the value in the examination of mortality data. We believe, however, this must be viewed in conjunction with other factors including:

- number and severity of comorbidities (multiple illnesses),
- cause of death when that death occurred after dismissal (HCFA's data included all deaths occurring within 30 days of admission, including those occurring after discharge),
- discharge source (i.e., to a hospice),
- and source of admission (i.e., from a long-term care facility such as a nursing home).

It is our belief, however, that a hospital should be committed to the continual improvement of patient care. Saint Joseph Hospital maintains numerous on-going programs and methodologies for this purpose. Through this on-going process, ways to improve patient care are constantly monitored and implemented.

Again, thank you for allowing us the opportunity to respond to the HCFA Mortality Data. It is our hope that in future years this study will evolve into a valuable tool by which patients can judge quality of hospital care.

Sincerely,

Kevin R. Andrews,
President

Medicare Provider number 45-0043

1401 South Main Street / Fort Worth, Texas / 76104 / 817-336-9371
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534—8857 AREA CODE 512

SAN ANTONIO STATE CHEST HOSPITAL

P.O. BOX 23340 (2303 S. E. MILITARY DR.) SAN ANTONIO, TEXAS – 78223

Robert Bernstein, M.D.
Commissioner of Health

Robert E. Neimes, M.D.
Hospital Director

A UNIT OF THE
TEXAS DEPARTMENT OF HEALTH

October 14, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Attached are comments concerning the mortality information release scheduled for December, 1987. These comments are in response to your letter dated September 21, 1987.

We are appreciative for the opportunity to comment.

Sincerely,

EARL C. McSWAIN, JR.
Deputy Director for Management
and Administration

th

Attachment

San Antonio State Chest Hospital
San Antonio, Texas

6 October 1987

The actual mortality rate calculated in this report is misleading in the following areas: (1) Cerebrovascular Accidents, (2) Severe Chronic Heart Disease, and (3) Sepsis.

Specifically this hospital treated only three patients with cerebrovascular accidents and one of them died which results in a actual mortality figure of 33%. There were six total cases of severe chronic heart disease and there were two deaths which results in a figure of 33% for this category. Similarly, there were two patients with sepsis and one of them died which resulted in a calculated figure of 50%. The small number of patients artifically inflates the actual mortality rate and makes it a meaningless figure.

ID NO. 450734

TX 402.1

Methodist

San Jacinto Methodist Hospital
An Affiliate of The Methodist Hospital
1101 Decker Drive
Baytown, Texas 77520
(713) 420-8600

October 23, 1987

Harvey Brook
HSQB - HCFA
6325 Security Blvd
Meadows East Building
Room 2-D-2
Baltimore, Md. 21207

Provider Number
450424

Dear Mr. Brook:

San Jacinto Methodist Hospital is a 186 bed acute care facility, whose case mix includes patients with medical and surgical illnesses. We are a full service hospital offering secondary level of care, including such high acuity services as a Heart Emergency Center, Neurosurgical Services, and a Level II Neonatal Nursery.

The Medical Staff Committees at San Jacinto Methodist Hospital conduct an intensive review of the medical record of **every** patient who dies at our hospital regarding medical management and appropriateness of care. Death review is a part of the ongoing process of the Quality Assurance program, and the physician peer review activities are a key component in the monitoring of the health care delivery system at San Jacinto Methodist Hospital. The review is a constant process enabling us to identify opportunities to improve care.

The hospital specific mortality data reported by HCFA and all quality assurance studies will be carefully reviewed by our Hospital Administration, Medical Staff, Utilization Review Committee, Medical Staff Quality Assurance Committee, Emergency/Disaster Committee, ICU/CCU Committee, our Medical Records and Quality Assurance Directors, and by the Medical Staff as a whole.

As stated previously, our hospital patient care review is a continuous ongoing process and is conducted on each individual case regarding overall quality of care.

Sincerely,

Russ Schneider
Administrator

RS/pw

Santa Rosa
Medical Center
519 West Houston Street • San Antonio, Texas 78207 • Phone 512-228-2011

October 27, 1987

William L. Roper, MD
Administrator
Health Care Financing Administration
6325 Security Blvd.
Baltimore, MD 21207

Dear Dr. Roper,

We appreciate the opportunity given us by the Health Care Financing Administration to verify, analyze and respond to its 1986 mortality data for Santa Rosa Medical Center, prior to its release to the public.

Santa Rosa Medical Center is comprised of Santa Rosa Hospital, Santa Rosa Children's Hospital, Saint Rose Catholic Hospital and Villa Rosa, and is licensed for 1118 beds.

These comments will deal mainly with Santa Rosa Hospital, since all except 7 of the cases included in the data, were discharged from that facility.

Santa Rosa Hospital is a general, acute care facility providing tertiary care to 88 counties in South Texas. Licensed for 448 beds, Santa Rosa also enjoys a teaching affiliation with the medical and nursing schools located at the University of Texas Health Science Center in San Antonio, and with the nursing schools at Incarnate Word College and San Antonio College.

Founded in 1869 by the Sisters of Charity of the Incarnate Word, the mission of Santa Rosa has always been to provide the highest quality medical care to the people of San Antonio and South Texas "... irrespective of race, creed, color or social status". This is as much a part of our commitment and philosophy today as it was 118 years ago, and the reason Santa Rosa Medical Center delivered $25 million in uncompensated medical care to patients from across South Texas in 1986.

Santa Rosa Hospital operates several specialized programs, which we feel impact HCFA's mortality data. These include:

- a large dialysis unit
- a diabetes education and treatment program
- the Otto Koehler Radiation Treatment Center for cancer patients
- a GI lab
- a cardiac catheterization lab
- a home health program

All deaths at Santa Rosa Medical Center are reviewed by members of the medical staff to ensure appropriateness and quality of care. A Quality Assurance program has been in place for many years, the purpose of which is to identify opportunities to improve the quality of patient care delivered.

The mortality data sent to us by HCFA was verified and analyzed by Santa Rosa's Quality Assurance Coordinators, Medical Records Director and members of the medical staff. In all except one of the categories considered, Santa Rosa fell well within the predicted range, and in 11 of the 16 categories fell below the mid-point of the predicted range.

The only category in which Santa Rosa fell outside of the predicted range was that of Gastrointestinal Disease (GI). For the 293 cases considered in this category the range of predicted mortality was from 3% to 10%. Santa Rosa was attributed with a 2% mortality rate.

All charts for the 19 cases who died in house were reviewed again by Quality Assurance, Medical Records and a gastroenterologist to insure appropriateness of care. After review and discussion of the cases in question, the only conclusion that could be drawn was that the lower than predicted mortality rate accurately reflected the high quality of care delivered to GI patients at Santa Rosa Hospital.

In comparing the mortality data sent by HCFA with Santa Rosa's own medical records, several discrepancies were found. *(To maintain patient confidentiality, we have attached a separate list which identifies each patient by HIC ID Number, and describes the nature of the discrepancy found.)*

HCFA attributed 385 total deaths to Santa Rosa, 301 occurring while the patient was in house, 84 after the patient had been discharged.

Santa Rosa's Quality Assurance coordinators were able to conduct verification on all 385 cases. They found that 309 deaths occurred in house, while 71 deaths occurred after the patient had been discharged from the hospital. Five should be subtracted from the total since the discharges were from Villa Rosa, a non-acute care facility. In its criteria HCFA has stated that only " ... short term acute care hospitals ..." will be considered in this study.

Of the 71 who died after discharge:

- One patient left Santa Rosa against medical advice.
- One patient was transferred to Audie Murphy Veterans Administration Hospital, but is attributed to Santa Rosa since government facilities were not considered in the HCFA data.
- One case in which the date of death was the same as the date of discharge, according to the medical record the patient was "discharged home to self care, walked to car". Further verification with the Texas Department of Vital Statistics showed no record of this patient's death.

- Another case in which the date of death was the same as the date of discharge, the patient was transferred to Audie Murphy Veterans Administration Hospital. Again, this discharge is attributed to Santa Rosa since government facilities were not considered in the HCFA data.

In anaiyzing this data we felt it relevant and important to investigate patient origin and develop a profile of the Medicare patients discharged from Santa Rosa Medical Center during 1986.

We found that:

- 64.48% of Santa Rosa's Medicare patients reside in 12 zip codes within close proximity to the downtown hospital;
- the median household income for these 12 zip codes averaged $16,295.00 per year (ranging from $10,580 to $23,123) with 8 of the 12 falling below that level.
  (According to the U.S. Census Bureau, in 1986 the median household income for the United States was $29,458.00);
- the median years of school completed for these 12 zip codes averaged 10.6 years, ranging from 7.0 to 12.4 years
  (According to the U.S. Census Bureau, in 1985 the median years of school completed by all persons aged 25 and over in the United States was 12.6);
- the median home value for these 12 zip codes is $28, 053.33
  (According to the U.S. Census Bureau, in 1983 the median home value in the Southern region of the United States was $52,100.00).

It has been consistently documented that individuals from lower socioeconomic levels have more limited access to prophylactic health care throughout their lives. In later years this lack of consistent, preventative health care results in more severe and complex onset of physiological problems. As illustrated in the information above, we find that the greatest percentage of Santa Rosa Hospital's Medicare patients fall into this group.

In addition we found that:

- the patients considered in the study ranged in from 21 to 107 years in age, the distribution is broken out below.

AGE	# of PTS	% of Total
<65	25	6.6%
65-69	38	10%
70-74	62	16.3%
75-79	69	18.2%
80-84	66	17.4%
85-89	64	16.8%
90-94	35	9.2%
95-99	18	4.7%
>100	3	0.8%

• for 73 % of the deaths occurring in the hospital (225 out of 309 cases), a physician order had been given to refrain from use of extraordinary measures to preserve life. The Do Not Attempt Resuscitation (DNAR) order is made **only at the request of the patient and/or family to allow patients to die with dignity in cases of irreversible illness.** It is a fundamental belief and practice of Santa Rosa Medical Center to support the individual in accepting death as a free human act, a liberating act which enables one to surrender this life and be united to God for all eternity.

We feel that these findings are significant because:

a. they help describe the environment from which the bulk of our Medicare patients originate, and

b. they can be used as indicators of the patient's physical condition at time of admission to the hospital.

We congratulate HCFA for taking this initial step in an effort to assure the highest quality medical care for ALL consumers in this country. However, we recognize - and hope the public will recognize - the fact that the release of this mortality data is just that, a first step in developing criteria to evaluate the quality of medical care.

As we have demonstrated in the information above, several important components which are accepted to affect the probability of death in **each individual** case, have not been given consideration in this data. For this reason we were encouraged to read in Dr. Roper's cover letter "... the information on its own is not a complete measure of the quality of care at an individual hospital." In this light, we also hope that HCFA will strongly caution consumers not to use the mortality data as the sole source of information for deciding which hospital to use.

At the same time, recognizing the value of such information to both public and hospitals, and understanding the enormity and difficulty of the task, we urge HCFA to continue refining the statistical model used, so that it will more accurately reflect the many factors which can and do affect the severity of an individual patient's disease. In this way, we feel such an exercise will be more meaningful for hospitals and those we serve in our communities.

Sincerely,

T. H. Rockers

Thomas H. Rockers
President
Santa Rosa Medical Center

Scenic Mountain Medical Center

1601 West Eleventh Place
Big Spring, Texas 79720-9990
Tel. (915) 263-1211

October 16, 1987

Dr. William Roper, Administrator
Department of Health and Human Resources
Washington, DC 20201

Dear Dr. Roper:

Scenic Mountain Medical Center is a 153-bed acute care hospital located in Big Spring, Texas. We offer a full range of medical/surgical services including a level 3 emergency room, an 8-bed intensive care unit, a 20-bed alcohol and drug abuse rehabilitation unit, and obstetrics.

We have reviewed the 1986 mortality information for this institution. Based on an analysis of the statistical information released, Scenic Mountain Medical Center was within the "range of predicted mortality rates" for all diagnostic categories as set specifically for Scenic Mountain Medical Center. Based on the HCFA study and reported results, we do not see a particular mortality problem at this institution.

All deaths that occur at Scenic Mountain Medical Center are reviewed in departmental committees consisting of physicians and hospital professionals. The quality of care at Scenic Mountain Medical Center is constantly reviewed internally through a series of committees and externally by the Peer Review Organization (PRO) and the Joint Commission Accreditation of Hospitals (JCAH).

Deaths that occur outside the hospital are not reviewed internally. The HCFA study included deaths that occurred within 30 days of discharge from the hospital. The fact that all of these deaths were not directly related to the illness that hospitalized the individual should be mentioned. Also, some of these patients were terminally ill and were discharged from the hospital to a nursing home or another medical facility. The decision to discharge these patients rests solely with the physician and family.

Thank you for the opportunity to respond to the mortality study and resulting findings for Scenic Mountain Medical Center.

Sincerely,

Michael C. Deaton

Michael C. Deaton
Acting Administrator

MCD:ng

Schleicher County Medical Center
Eldorado, Texas

Provider Number: 45-0735

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.

SCOTT&WHITE

October 28, 1987

HCFA
Department Health & Human Services
ATTN: HSQ--148--GNC
P. O. Box 26676
Baltimore, Maryland 21201

Dear Mr. Brock:

As requested the information pertaining to mortality data regarding Medicare patients was seriously reviewed by members of the medical and administrative-staff of our hospital. The report provided by Health Care Financing Administration provides another opportunity for our staff to evaluate services provided to our patients, and also a chance to evaluate the accuracy and relevancy of the HCFA report.

We are very pleased to observe that the HCFA data reports that patients receiving care at Scott & White Memorial Hospital fell within the predicted ranges. Physician specialists and administrative reviewers at Scott & White have further analyzed each case listed in the 16 diagnostic categories selected by HCFA and are further satisfied that these patients did receive excellent care. The HCFA data will be included in the other ongoing quality assurance programs utilized at our institution to monitor and assure quality health care.

Analysis of the HCFA data suggests several areas to be re-evaluated if we are to accurately access quality of health care from this type of report.

A major problem appears to be grouping of diagnostic codes into selected categories, an example being patients admitted under "low risk heart disease". A patient may appropriately be assessed as low risk on admission, but as the disease process progresses, the patient often requires intensive diagnostic procedures and monitoring, proceeding to angioplasty or cardiovascular surgery, with the associated expected mortality related to severe heart disease.

A second example might be patients listed under the category of sepsis. Even though our results were within the predicted ranges, our review of these specific cases reveal that infection was only an associated event that occurred in patients with other documented terminal diseases, patients that properly requested personalized care with dignity rather than inappropriate aggressive therapy or resuscitation.

SCOTT & WHITE CLINIC
An Association Affiliated With Scott and White Memorial Hospital and Scott, Sherwood and Brindley Foundation

TEXAS A&M UNIVERSITY COLLEGE OF MEDICINE, TEMPLE CAMPUS

2401 South 31st St. Temple, Texas 76508 817/774-2111

HCFA
Department Health & Human Services
ATTN: HSQ--148--GNC
P. O. Box 26676
Baltimore, Maryland 21201

ATTN: Mr. Harvey Brock

Also, it will be very important to recognize that referral tertiary centers, such as Scott & White, receive critically ill patients with progressive or terminal diseases, conditions that are associated with increased mortality rates. The 1986 HCFA data does not reflect the size of hospital or severity of disease in the selected independent variables. Adjustment for severity of illness was attempted by considering co-morbid conditions in the 1986 data, however this may not completely account for the important variables of patient transfers or levels of care provided by different hospitals. We are gratified with our performance in 1986, but would suggest that these other important factors be considered in the overall analysis.

In summary, we are pleased to note that our mortality data at Scott & White is reported well within the predictable ranges for our hospital. We accept the report as one parameter to attempt to evaluate total health care. It will be included with our other internal quality assurance monitoring that is collected internally and is also provided by other sources through our medical associations and state and local agencies. We will also work with HCFA and other agencies to work toward the goal of developing accurate information systems that will assure high standards of health care and will also allow the public to judge the quality of medical care provided by health institutions throughout the country. We hope our response and suggestions are helpful.

Yours truly,

Dudley P. Baker

Dudley P. Baker, M. D.
Associate Chief of Staff
Scott & White Memorial Hospital and
Scott, Sherwood & Brindley Foundation

Medicare acute #450054

DPB:eam

October 22, 1987

William Roper, M.D., Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

We have reviewed the data on hospital mortality statistics for January 1, 1986, to December 31, 1986. The director of Medical Records has validated that, with minor exceptions, the data is essentially correct.

Please note the following responses to specific items.

I. Seton Medical Center is within normal ranges for all deaths. Medicare deaths attributed to Seton Medical Center numbered 455 for the 1986 calendar year. Of these, 59 died after discharge but within 30 days of their last admission to Seton.

These 59 patients had the following demographic and medical characteristics:

* 32 (54%) were 75 years of age or older
* 54 (92%) had terminal illnesses, or more than one lingering, disabling condition

II. Seton had 27 patients with a principal diagnosis of sepsis (DRG #416 and #417). Seventeen of these patients died.

Please note that of these 17 patients, 15 (88%) had underlying terminal illnesses or multiple severe health problems, and requested that they not be resuscitated.

All patients requesting a "no resuscitation" status receive therapeutic care, and every effort is made to keep the patient comfortable. Patients requesting a return home are accommodated if at all possible.

SETON
MEDICAL CENTER
Sponsored by the Daughters of Charity of St. Vincent de Paul
1201 West 38th Street • Austin, Texas • 78705-1056 • (512) 459-2121

Seton Medical Center is a 465-bed acute care, diagnostic, and surgical referral center for a 10-county region in Central Texas. We offer care in all specialty areas of medicine, surgery, and obstetrics. Review of patient care is routinely conducted on every patient at Seton Medical Center, as part of our Quality Assurance Program.

The mortality data reported by HCFA have been reviewed by the president and CEO of Seton Medical Center, president of the Medical Staff, physician chairman of the Quality Assurance Committee, and the director of Quality Resource Management.

Sincerely,

Judith P. Smith
President/CEO
Seton Medical Center

James Lindsey, M.D.
President, Medical Staff
Seton Medical Center

c: Sister Mary Rose McPhee
Regional Executive
DCHNS - West Central

Shamrock General Hospital

Owned & Operated By

South Wheeler County Hospital District Precincts 3 & 4

1000 S Main Street P. O. Box 511 Phone 256 2114

Shamrock Texas 79079

October 14, 1987

William L. Roper, M.D.
Administrator, Department of Health
and Human Services
Health Care Financing Administration
Washington, D. C. 20201

Dear Dr. Roper:

I have reviewed the list of Medicare patients who died in the hospital or within 30 days of discharge.

This list and the details surrounding the release of this information to the general public was on the agenda of my last board of directors meeting. The directors were concerned that this information would be misleading to the general public. Three items to submit for public comment are:

1. In many instances patients come to our hospital from other areas specifically to be taken care of by family in our area. Patients classified in these diagnostic groups could have just as easily been a statistic of another hospital.

2. The acuity level of Medicare patients has increased with the Prospective Payment System. The criteria based admissions are selective of the more acutely ill elderly. This can account greatly towards the increase in hospital death rates. If patients could be taken care of, as they should be, their conditions could be easilier managed with better death statistics for outcomes.

3. The Health Care Financing Administration is now using the analogy that the reason for increased cost to the Medicare Part B program is due to higher charges by doctors and hospitals. This is not the greatest cause

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

for the higher Part B. cost. The reason should be directly related to the direction of health care being changed from Inpatient to Outpatient by the prospective payment system.

Thank you for your attention to this matter.

Sincerely,

Joe M. Duerr
Administrator
Shamrock General Hospital

JMD:wk

Enclosure

SHANNON MEDICAL CENTER

October 27, 1987

Mr. William L. Roper, M. D., Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for 1986. The information pertaining to our facility has been reviewed and analyzed by an administrative team, Medical Records representative, Medical Care Evaluation Committee members and our medical director of Quality Assessment.

Shannon West Texas Memorial Hospital is a short-term acute care facility that provides approximately 95 percent of the charity care that is provided in our area without benefit of tax support. We have the major trauma center for the area and provide full services including oncology, neurosurgery and acute dialysis. In addition to caring for the majority of the indigent population, we have also been determined to be a disproportionate share provider and these two factors combined would indicate that the patients we care for are, on an average, sicker than the normal hospitalized patient. We are unable to determine specifically that the regression model for determining the range of predicted mortality rates for our hospital included these factors. We were pleased, however, to see that we fell within the range of predicted mortality rates in all categories.

Our review team has verified that, with minor exception, the data is accurate in regard to deaths within the hospital. The statistics provided by Health Care Financing Administration includes 55 deaths, or 24 percent of total, occurring after dismissal from the hospital. Of those patients that died outside the hospital, 50 percent of them died within a week of dismissal from the hospital and the remaining 50 percent died in excess of one week following dismissal from the hospital. Since these deaths occurred outside of our facility, we have no way of knowing whether the cause of death was related to the condition for which they had been previously hospitalized. Many of the patients were discharged to nursing homes or to Hospice care for terminally ill.

Our review team has analyzed the inpatient deaths related to cerebrovascular accidents, pulmonary diseases and sepsis. These three diagnostic categories were selected because they were closer to the upper limits of the range of predicted mortality rates but they were within the predicted range. In conducting our analysis, we incorporated the co-morbid condition that is defined by your organization as having a significant impact on the patient's outcome.

SHANNON WEST TEXAS MEMORIAL HOSPITAL
120 E. HARRIS P.O. BOX 1879 SAN ANGELO, TEXAS 76902 (915) 653-6741

The inpatient deaths that fell in the diagnostic category of cerebrovascular accidents included 85 percent with co-morbid conditions and 22 percent of these patients had multiple co-morbid conditions. The patients that were diagnosed as pulmonary diseases reflected 61 percent with co-morbid conditions and 42 percent of these patients had multiple co-morbid conditions. The inpatient deaths that fell in the diagnostic category of sepsis indicated 67 percent had co-morbid conditions and 17 percent had multiple co-morbid conditions. These high ratios of co-morbid conditions combined with the economic status and the ages of the Medicare patients being treated would result in a higher than expected mortality percentage; however, with the fine medical staff that we have, we were still able to stay within the range of predicted mortality rates.

Thank you for the opportunity of analyzing and commenting upon the report.

Sincerely,

Thomas G. Alexander

Thomas G. Alexander
President

JF:lc

October 7, 1987

Burnet
County
Hospital
Authority
dba
Shepperd Memorial Hospital

501 Buchanan Drive
Burnet, Texas 78611
512 756-2141

Fully Accredited By The
Joint Commission
on Accreditation
of
Hospitals

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We have reviewed the mortality data submitted by your office on September 21, 1987, concerning the Medicare deaths charged to this hospital during the year 1986.

It is particularly interesting that of the 80 Medicare deaths you reported, the average age of the patient at the time of death was 79.08; the average age at the time of death of male patients was 78.2 and female patients was 80.

I would like to comment on the age of patients at the time of death, inasmuch as it exceeds the national life expectancy average. Modern Healthcare's September 25, 1987 issue reports that the average life expectancy has risen to 74.9 years which means that the average age of patients whose deaths are charged to this hospital exceeds the present life expectancy by 4.18 years. Thus, we are proud to be represented in this category, as we would think that this demonstrates superior health care delivered in this community.

A further review of your morbidity data reflects that all principal diagnoses are correct; however, there are several patients whose actual cause of death was a secondary diagnosis.

A review of the patient's place of death reflects 67 patients expired in the Shepperd Memorial Hospital and 13 elsewhere. Ten of the 13 died in nursing homes and three expired at home.

A comparison of the actual mortality rate to the range of predicted mortality rates demonstrates that, with the exception of cancer as the cause of death, all other causes of death occurring to patients in this hospital, were well within the range of the predicted mortality rates. It should be noted, however, that many of the deaths charged to this hospital represented patients who had received surgical treatment at other hospitals and were returned to this facility in a terminal state.

We note that your summary sheet reflects a total of 439 Medicare patients admitted during the reporting period, however, our records demonstrate that there were 740. Therefore, the statistical application made on your summary sheet is skewed higher in the actual mortality rates.

Sincerely,

JOHN J. HAYES
Administrator

JJH:pm

copy to: Board of Trustees
Chief of Staff

SHINER
HOSPITAL
INCORPORATED

P. O. Box 85 — 118 N Ave. D • Shiner, TX 77984-0085 • 512/594-3325

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Gentlemen:

Enclosed is a statement we at Shiner Hospital, Inc. would like for you to publish along with our hospital mortality data.

The average age of Shiner Hospital, Inc. patients in this mortality study is 86 years old. Consider the fact that Shiner Hospital, Inc. has a very high percentage (over 75%) of Medicare patients, the age of our patients, and that many had more than one complication. These are factors which affect our patient mortality rate, but do not show up in these statistics.

Sincerely,

Wayne J. Jalufka
Administrator

WJJ:pv

L. Marcus Fry, Jr.
CHIEF EXECUTIVE OFFICER

Sierra Medical Center

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

In reference to the public commentary period involving the public release of hospital mortality rate, please be advised that hospital mortality rates cannot be used to measure hospital performance as they are only a statistical analysis of "expected mortality" based on selected patient characteristics. This predicted mortality rate is achieved through the identification of deaths which occurred within thirty days of admission to the hospital. This methodology may attribute deaths to the hospital which were unrelated to the hospitalization. The statistical analysis is no more than a prediction of the "risk of death" and does not reflect the acuity level of patients treated, nor does it reflect all factors which could influence death. Sierra Medical Center has the highest case mix index of any major acute care facility in El Paso indicating that patients treated at Sierra are more acutely ill than average. (Case-mix index is a numerical reflection of severity of illness.) The statistical analysis does not predict hospital mortality rates, rather it is a reflection of the relationship between a small number of patient characteristics and the risk of death. Hospital mortality rates should not, under any circumstances, be used as the basis for judging the quality of care provided by different hospitals. It is only through careful analysis of the medical record that quality of care can be determined.

Very truly yours,

L. MARCUS FRY, JR.

/bm

(915) 532-4000 • 1625 Medical Center Drive • El Paso, Texas 79902

SOUTHEASTERN METHODIST HOSPITAL

9202 Elam Road Dallas, Texas 75217

October 20, 1987

William L. Roper, MD
Administrator
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

The following information regarding the 1986 mortality rates for Southeastern Methodist Hospital is in response to the release of data to be published in December 1987. Since receiving the report dated September 21, 1987, Southeastern Methodist Hospital staff has had the opportunity to review and analyze the data.

Southeastern Methodist Hospital is a 172 bed general acute care facility. We offer the community a full range of high quality inpatient and outpatient health care services including internal medicine, obstetrics, pulmonology, gastroenterology, alcohol detoxification and rehabilitation, as well as general and orthopedic surgery. Southeastern has an active day surgery and cardiac rehabilitation program. Additionally, we have an eight bed intensive care unit and a full service emergency care center.

As part of our commitment to quality, the medical staff at Southeastern Methodist Hospital intensively reviews the medical record of every patient who expires at this facility. The medical management and overall care is examined and discussed by the physicians reviewing the case. Mortality review is an on-going function of the Quality Assurance program. Physician review activities are an integral part of the monitoring of the health care delivery system at Southeastern.

In addition to the medical staff Quality Assurance activities, Southeastern assists patients and their families with discharge planning needs through our Social Services department. The Social Services department arranges for post hospitalization home care services and nursing home placements. The quality of these services is reflected in the low mortality figures for patients outside the hospital.

The mortality data reported by the Health Care Financing Administration (HCFA) has been carefully reviewed by: the Executive Director, Chairman of the Board of Trustees, President of the Medical Staff, Physician Chairman of the Department of Medicine, Physician Chairman of the Department of Surgery, Physician Chairman of the Medical Record/Utilization Review Committee, Physician Chairman of the Patient Care Committee, Director of Quality Assurance and the Manager of the Medical Record Department. With minor exceptions, the data have been validated as being accurate.

Overall, the actual mortality rates for each of the diagnostic categories identified by the HCFA fell within the range of predicted mortality rates estimated by the HCFA.

A comprehensive review of the data and the corresponding medical records show that 82% of the patients who expired had long term, multiple medical problems. Additionally, 31% of the patients came to the Emergency Department with critical, life-threatening conditions. Because of the multiple medical problems and critical conditions of the patients, 64% of the families had requested that no resuscitation be performed should a cardiac or respiratory arrest occur.

Southeastern Methodist Hospital is committed to providing high quality patient care. We will continue to review all mortality cases in an endeavor to assist in identifying opportunities to improve patient care.

Thank you for the opportunity to present this information.

Sincerely,

Gene R. Barron
Executive Director

David Merkin MD

David Merkin, MD
President of Medical Staff

GRB/lfc

SOUTHWEST
GENERAL HOSPITAL

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Consideration of factors such as patient compliance after discharge and transfer to other health care facilities need to be addressed in the inclusion of mortalities within thirty (30) days after admission to the hospital. In addition consideration of preadmission treatment, such as emergency care outside of the hospital, has an overall effect on the outcome of some high risk diagnostic categories. Your consideration of these and similiar factors would be beneficial in future comparisons of mortality rates.

Sincerely,

Steve G. Jackson
Administrator

SGJ/cg

7400 Barlite San Antonio, Texas 78224 (512) 921-3511

SOUTHWEST TEXAS METHODIST HOSPITAL
Provider #450388
San Antonio, Texas

RESPONSE TO HCFA MORTALITY STATISTICS

Methodist Hospital is a 573-bed, acute-care facility recognized as a regional referral center. We are a full service hospital offering care in the specialty areas of oncology, cardiovascular disease including open-heart surgery, neurological and orthopedic trauma, also high-risk maternal and child care.

Because we place a high value on quality care, our Quality Assurance Department conducts an ongoing review of every patient's care. Our physicians and nurses are actively involved in this review process. Medicare's mortality statistics serve as another tool to guide us in our quality review process.

We are pleased to note that the mortality rate for every category fell within the expected range; nevertheless, because of our dedication to quality care we completed an in-depth review of the data. This review further confirmed that we are providing excellent care. Even in the sepsis category, where we experienced our highest mortality rate, our review noted quality treatment. Medical literature indicates that when sepsis co-exists with other conditions, mortality rates of up to 80% might occur in spite of ideal care. All patients who died with sepsis at Methodist Hospital suffered from complications such as kidney or cardio-respiratory failure, stroke, cancer, or shock. Most had been hospitalized previously and 7 (44%) were transferred to Methodist from other hospitals. About 70% of these deaths occurred in patients over 80 years of age.

We appreciate the opportunity to respond to this data.

John E. Hornbeak
Chief Executive Officer

Kathryn Safford, M.D.
Chairman, Medical Staff Quality Assurance Committee

John Holcomb, M.D.
Chairman, Medical Staff Medical Records Committee

SPOHN HOSPITAL
A Mission of Caring Since 1905

600 Elizabeth Street
P.O. Box 3666
Corpus Christi, Texas 78404
Telephone 512-881-3000

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates of Medicare patients.

Spohn Hospital is a 560-bed regional medical center offering advanced care for the people of South Texas. Our services, for patients within a 12-county area of the Coastal Bend, include such specialities as comprehensive diagnosis and treatment of heart disease including open heart surgeries, complete cancer care and radiation therapy services, the area's renal dialysis program, major orthopedic services, and rehabilitative medicine, as well as general medicine and surgery. Spohn's mission, since our founding in 1905, has always been to provide high quality, compassionate care.

Mortality review has long been considered part of the patient care evaluation process here at Spohn and we routinely work very closely with our medical staff to monitor mortality rates, using them to guide our internal quality assurance and peer review mechanism. The Joint Commission on the Accreditation of Hospitals (JCAH) also encourages such mortality review and they, as recently as July 1987, bestowed upon Spohn another three-year accreditation.

In reviewing the mortality data you reported for some of our Medicare patients, we are pleased to note that Spohn Hospital remains well within, and in fact at the low end of, the average mortality rate ranges you provided. We are especially pleased with these statistics, since Spohn is the regional referral center for South Texas and thus treats many severely ill patients, often transferred here from other community hospitals. Patients are commonly transferred to Spohn for advanced cancer and heart care and 30 percent of our patients are transferred from outside of our immediate area. In addition, Spohn offers one of the area's only specialized programs for the terminally ill.

Providing the highest quality of care possible is of utmost importance to the medical staff, administration, board of trustees and employees at Spohn Hospital. We feel that is evidenced in the large range of specialty services we provide and in our eagerness to reach out to provide care to all of South Texas.

Again, thank you for the opportunity to review the data.

Sincerely,

Sr. Kathleen

Sister Kathleen Coughlin, F.A.C.H.E.
President

TX 432.1

SPOHN KLEBERG
MEMORIAL
HOSPITAL

1300 General Cavazos
P.O. Box 1197
Kingsville, Texas 78363
Tel. (512) 595-1661

ALLAN C. SONDUCK
Chief Executive Officer

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

We have received the HCFA mortality rate statistics for our hospital and would like to submit the following comments.

Spohn Kleberg Memorial Hospital is well within the HCFA range of predicted mortality rates on all diagnostic categories with one exception. This one exception is the "cancer" diagnosis where our actual mortality rate is 1% higher than the range of predicted mortality rate. Although this is not a significant variance, there are several other factors which should be considered with this report.

In reviewing the HCFA mortality rates, it is extremely important for the community to realize that the quality of health care cannot be inferred from mortality rates or any other single statistical analysis. Quality of patient care is measured by a comprehensive quality assurance program. This encompasses the holistic approach to medicine - from the medical treatment to social services to discharge planning and home care. Concurrent and prospective review of patient care can provide a more realistic picture of the quality of health care being provided. These review functions examine many indicators of quality including blood use, surgical cases, medical necessity, antibiotic usage, medication use, and mortality review. Through such reviews, areas of concern can be promptly identified and addressed.

In addition, our patient care surveys tell us what quality of care our patients feel they are receiving. This data consistently shows us a high rating and provides valuable information on how our patients perceive their hospital stay.

Our hospital is also accredited by the Joint Commission on Accreditation of Health Care Organizations. This national organization has established criteria for standards of good health care which are universally recognized by the health care industry. Survey by the Joint Commission is voluntary; however, we feel the accreditation status from this organization is a bench mark of quality which does take into consideration a wide range of monitors. This, we feel is a better indicator of health care quality than simply looking at mortality rates.

As a small rural hospital, we are the sole provider to a community which has a large elderly population. Approximately 43% of our entire patient population is Medicare admissions. Therefore, we serve all of the community needs as a tertiary care provider.

The mortality reports published by HCFA provide only a small piece of information about a hospital. Although our mortality report is very favorable to us, the faults of this data must not be ignored. Each patient is an individual case whose outcome depends on so many other factors (such as family situation, previous health, will to live, etc.). All of these factors are incorporated into the holistic approach to medical care at Spohn Kleberg Memorial Hospital to help return the patient to an improved state of health. The HCFA mortality rates not only includes the patients who do not improve and die in our hospital, but also the patients who do improve and are discharged, and then die within 30 days of admission. These deaths are included in the hospital's mortality rate even though they did not die in the hospital! They could have died from an accident, or homicide or suicide - events which have nothing to do with their hospitalization or hospital care.

It is important to remember that health care is a personal choice. A choice based on a physician's recommendation, personal experience, accessibility and/or word of mouth reputation. Statistics such as the HCFA mortality rates should not be the basis for choosing a health care facility. Even though Spohn Kleberg Memorial Hospital fairs very favorable on the HCFA mortality rates, we strongly believe that these statistical reports should not be the sole basis for choosing such a personal service on health care.

Thank you for the opportunity to express our views.

Sincerely,

Allan C. Sonduck

HCA Spring Branch Memorial Hospital

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

RE: Mortality Statistics
Spring Branch Memorial Hospital 1986-87

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data of hospital mortality rates for 1986-87. Since receiving the report dated September 21, 1987, Spring Branch Memorial Hospital's staff has had an opportunity to review the data. Spring Branch Memorial Hospital is a 365 bed acute care facility, whose case mix includes many patients with major medical and surgical illness. We are a full service hospital offering care and specialty areas of oncology, open-heart surgery, major orthopaedic services, dialysis, as well as general medicine and surgery.

The Medical Staff of Spring Branch Memorial Hospital conducts an intensive review of the medical record of every patient who expired at the facility regarding medical management and overall care. Mortality care is an ongoing process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the health care delivery system at our hospital.

The hospital's specific mortality data reported by HCFA has been carefully reviewed by the hospital administrator, president of the Medical Staff, physician chairman of the Utilization Review Committee, physician chairman of the Quality Assurance Committee, the Administrative Director of the Medical Staff Services and the Utilization Review Coordinators. Our overall percentage of death is within the range of the predicted mortality rates for our hospital.

After receipt of the report, all deaths were reviewed by the Utilization Review coordinators, Administrative Director of Medical Staff Services, and the chairman of the Quality Assurance Committee. We noted four mistakes with the dates of deaths, ten ages were incorrect, one admission date incorrect and two patients on the report were not admitted to Spring Branch Memorial Hospital.

8850 Long Point
P. O. Box 55227
Houston, Texas 77055
Telephone (713) 467-6555
A Subsidiary of HCA, The Healthcare Company

The Medical Staff of Spring Branch Memorial Hospital will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patients.

Any reviewer should understand the limitations of this summary data by DRG which does not reflect the differences in diagnosis, procedures, severity of illness, case mix, age, complications and reason for death. Differences in data between hospitals should not be interpreted as a difference in the quality of care.

Thank you for this opportunity to present this response.

Sincerely,

Ben Rosenthal, M.D.

Ben Rosenthal, M.D.
Chief of Medical Staff
Spring Branch Memorial Hospital

BR/cmh

ST. DAVID'S
COMMUNITY HOSPITAL

BOARD OF TRUSTEES
John A. Barclay
Chairman
Robert Mueller, Jr.
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David R. Wilson
Secretary
Robert T. Present
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T. James Bethell
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Charles M. Christensen
Peter T. Flawn, Ph.D.
C. W. Hetherly, Jr.
Alfred A. King
John E. Neff III
Jon P. Newton
William A. Walker, M.D.
John P. Watson

President, St. David's
Auxiliary

President, St. David's
Medical Staff

HONORARY LIFE MEMBERS
John T. Mahone
Wm. C. Milstead
Gatewood Newberry

PRESIDENT
Jack L. Campbell

October 21, 1987

William L. Roper, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The following information for St. David's Community Hospital is to be attached to the hospital specific report for 1986, prior to public disclosure.

St. David's Community Hospital is a 331 bed acute care facility which provides services for patients with major medical and surgical illnesses. We are a full service hospital offering care in specialty areas of oncology, neurology, open-heart surgery, major orthopedic services, emergency care as well as surgery and medical diagnostics.

The medical staff at St. David's Community Hospital has an extensive and ongoing quality assurance program which includes the review of every mortality at this facility by a physician committee. This allows each case to be evaluated for appropriateness of medical management and overall care thereby assuring the highest quality within our health care delivery system.

St. David's specific mortality data as reported by HCFA has been carefully reviewed by both the hospital administration and medical directors. We feel that the reported results are consistent with the high quality of medical care being provided at this hospital.

Thank you for the opportunity to present this response.

Sincerely,

Jack L. Campbell, FACHE
PRESIDENT
JLC:de

512/476-7111

919 East 32nd Street
P.O. Box 4039, Austin, Texas 78765-4039

St. Edward Hospital

MEDICARE #450048

October 20, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics for calendar year 1986 prior to public disclosure. Our Medical Records Department has reviewed the report and finds the majority of the data is accurate, even through it does not take into consideration the entire MEDICARE population treated at the hospital. In addition, the hospital Medical Staff has reviewed these statistics as a portion of their on going quality review process.

St. Edward Hospital is a 50 bed non-profit acute care facility that is a part of the Sisters of Charity of the Incarnate Word Health Care System. We are a rural hospital whose mission is to offer care to all people in need, with an emphasis on the indigent and elderly. As a rural facility we treat a large percentage of elderly patients, which includes many people with serious medical and surgical illnesses.

The one outlier that occurred at St. Edward Hospital involved a HCFA category (sepsis) that had only one case, and that patient aged 92 died. The smallness of our facility causes much lower numbers of cases in each category, particularly when all cases are not couunted. For example, another case of sepsis was admitted during 1986, but because it was not that patient's final admission it was not counted. That valid case, however, makes our actual mortality rate for 1986 50 percent rather than 100 percent. A review of the same category over a three year period revealed a mortality rate of 33 percent which shows no significant variation from the predicted mortality rate range.

It should be noted that nearly one half of all death cases (16 of 35) were admitted directly from a nursing home perhaps indicating these patients were in rather poor health prior to admission. Additionally, the average age of all death cases was 83.6 which is nearly ten years over the average age of death in the United States.

The Medical Staff at St. Edward Hospital performs a comprehensive review of the medical record of every patient who expires to determine the

quality and appropriateness of services rendered. Quality Assurance and Medical Staff peer review activities are an integral part of monitoring the health care delivery at this hospital.

The differences in mortality rates between hospitals should not be interpreted as differences in quality of care. Our hospital plans to incorporate data from this report into our ongoing Quality Assurance and Utilization management program as one of many elements reviewed to maintain and improve the quality of care rendered.

Sincerely,

ROBERT M. SPILLE
Administrator

RMS:nl

TX 437.1



St. Elizabeth Hospital

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics for calendar year 1986 prior to public disclosure. Our Director of Medical Records has reviewed the report and find that the majority of the data is accurate, however, it does not take into consideration the entire Medicare population treated at the hospital. This data was also reviewed by the Medical Director, Utilization Review Committee and Administrative Staff of St. Elizabeth Hospital.

St. Elizabeth is a 497 bed nonprofit acute care facility that is part of the Sisters of Charity of the Incarnate Word Health Care System. Our patient population includes many people with serious medical and surgical illnesses. We are a full-service medical center whose mission is to offer care to all people in need, with an emphasis on the indigent and elderly. A large number of seriously ill patients and people whose conditions require continuous care, both inpatient and out, are attracted to our facility by the speciality care offered in the following areas: Cardiology and Cardiovascular Surgery, Orthopedic and Neurosurgery, Rehabilitation Services, Women and Children Services, and Cancer Treatment related services. In addition we offer dialysis service and treatment of chronic renal diseases, ventilator services and treatment of chronic heart and lung diseases.

In addition, the expertise found in our medical staff and the advanced technologies available in our hospital combine to make us a major referral center for this region. Examples of the technology available include magnetic resonance imaging, Computerized Axial Tomography, Cardiac Catheterization Laboratory, hyperbaric chambers, and the latest cancer treating technologies.

2830 Calder Avenue
P. O. Box 5405
Beaumont, TX 77706
409/892-7171

As a nonprofit health care provider, our mission is to offer an environment of hope, healing and peace to all who seek relief in times of birth, sickness, and death. We offer programs promoting health care and wellness including nutritional education, weight reduction center and exercise program.

The medical staff quality assurance program at St. Elizabeth hospital reviews all mortality cases for appropriateness of care. Quality Assurance and medical staff peer review activities are an integral part of monitoring the health care delivery system at this hospital.

The differences in mortality rates between hospitals should not be interpreted as differences in the quality of care. Our hospital plans to incorporate data from this report into our ongoing quality assurance and utilization management program as one of many elements reviewed to maintain and improve the quality of care rendered.

Sincerely,

Sr. M. Carmelita Brett

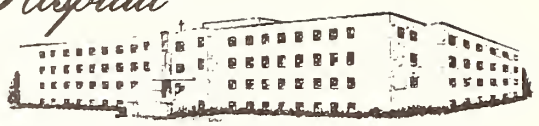
Sister M. Carmelita Brett
Administrator

SrMCB/lc

St. Elizabeth Hospital

Sisters of Charity of the
Incarnate Word, Houston

PHONE 675 1711
4514 LYONS AVENUE HOUSTON TEXAS 77020



October 20, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics for calendar year 1986 prior to public disclosure. Our Director of Medical Records has reviewed the report and finds the majority of the data is correct with the following exception:

Pt. [redacted] (as per attached) did not expire in our hospital as your report stated, rather was transferred to a rehabilitation facility. We would appreciate your help in correcting this error.

Review of these statistics was accomplished by the Utilization Review Committee. It should be noted that this report does not take into consideration the entire Medicare population treated at the hospital.

St. Elizabeth Hospital is an 88 bed non-profit acute care facility that is part of the Sisters of Charity of the Incarnate Word Health Care System. As a non-profit health care provider, our mission is to offer an environment of hope, healing and peace to all who seek relief in times of birth, sickness and death. St. Elizabeth serves a disproportionate share of medically underserved patients with an emphasis on the indigent and elderly. St. Elizabeth further serves these patients with an OB Clinic and telephone link between the hospital and the home bound infirmed.

The Medical Staff Quality Assurance Program at St. Elizabeth Hospital reviews all mortality cases for appropriateness of care. Quality Assurance and Medical Staff Peer Review activities are an integral part of monitoring the health care delivery system at this hospital.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

The differences in mortality rates between hospitals should not be interpreted as differences in the quality of care. Our hospital plans to incorporate data from this report into our ongoing Quality Assurance and Utilization Management Program as one of many elements reviewed to maintain and improve the quality of care rendered.

Sincerely,

Sister Mary Damian Murphy

Sister Mary Damian Murphy
Administrator

/bs

Attachment

St. John Hospital
Nassau Bay

October 22, 1987

William L. Roper, M.D.
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 20127

Dear Dr. Roper:

The following information for St. John Hospital is to be attached to the HCFA Mortality Data Release Report for the period of January 1, 1986, through December 31, 1986, prior to public disclosure.

St. John Hospital, Nassau Bay, is a 130-bed healthcare facility that provides adult and pediatric medical, surgical and obstetrical care. Offering a wide range of services, St. John Hospital serves all members of the community. Our primary goal is to provide quality care to our patients in a Christian and personal manner.

The Medical Staff at St. John Hospital conducts concurrent and retrospective reviews of patient care and develops monitoring procedures for, and makes evaluation of, the quality and efficiency of all patient care. Mortality review is noted to be an on-going process of the Quality Assurance program integrated and supported by peer review activities within the Hospital.

The Hospital specific mortality data reported by HCFA has been carefully reviewed and confirmed by: the Hospital Administration, the President of the Medical Staff, Physician Chairmen of the Quality Assurance Committee, Medical Records Manager, Quality Assurance Manager, and the Utilization Management Coordinator. The Hospital Mortality Rates are noted to have fallen within the predicted parameters established by HCFA; with the exception of one. Due to the representational sampling of one case, diagnostic category SE (sepsis) is noted to have exceeded t e predicted standard.

Dr. Roper, the administration and staff of St. John Hospital, are committed to review, improve, and constantly update our programs to ensure we are meeting the needs of our patients. If we may be of further assistance, please contact me at your convenience.

Sincerely yours,

Gary Stremel

Gary Stremel
Administrator

2050 Space Park Drive • Nassau Bay, Texas 77058 • (713) 333-5503

Member of the Sisters of Charity of the Incarnate Word Health Care Systems/Houston, Texas

ST. JOHN'S
Hospital & Health Center
A member of the Incarnate Word Health System

2018 Pulliam St.
San Angelo, Texas 76902-5741
915/655-3181

October 27, 1987 Medicare Provider Number 450376

1986 MEDICARE MORTALITY ANALYSIS FOR ST. JOHN'S HOSPITAL & HEALTH CENTER

The data provided by the Department of Health & Human Services-Health Care Financing Administration (HCFA) regarding Medicare patient deaths for St. John's Hospital & Health Center has been reviewed and compares to our records as follows:

HCFA reported 100 patient deaths, of these, 75 patients expired during hospitalization and 25 patients expired after discharge. The mean number of days following discharge for the deaths reported was 9.4 days. The diagnostic categories are appropriate for each patient reported.

St. John's records indicate that there was a total of 1843 Medicare admissions for 1986 which includes nine additional patients who expired during hospitalization for a total of 109 Medicare deaths or 5.9% of total Medicare admissions, whereas, HCFA reported a total of 1073 admissions and a 9% mortality rate.

St. John's data indicates the average length of stay for Medicare patients was 7.5 days and the average age was 76.

Utilizing either St. John's data or HCFA's data, St. John's Hospital & Health Center's mortality rate falls within the Range of Predicted Mortality Rate Norms both cumulatively and for each Diagnostic Category. Greater than 99% of the Medicare deaths were classified in High Risk Diagnostic Categories. Even though statistically no problems existed with the mortality rate, each case was reviewed for appropriateness of care. These case reviews revealed no deficiencies in care resulting in the death of a patient.

Through the Quality Assurance program at St. John's Hospital & Health Center, all deaths will continue to be reviewed as well as statistics evaluated as part of the ongoing process to maintain quality standards in health care delivery.

ST. JOSEPH HOSPITAL
& HEALTH CENTER
Sisters of St. Francis
2801 Franciscan Drive Bryan, Texas 77802-2544 (409) 776-3777

October 26, 1987

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

RE: Medicare Mortality Data, 1986
St. Joseph Hospital & Health Center, Bryan, Texas, Inc.
Medicare Provider Number: 450011

Dear Dr. Roper,

After careful review and minor corrections (attached) to the selected mortality information about Medicare patients treated by St. Joseph Hospital & Health Center, Bryan, Texas, Inc. in 1986, I wish to comment on the interpretation of the published data as well as the results and strategic implications for St. Joseph Hospital & Health Center.

It must be emphasized as stated in your letter to hospital administrators, "that the information on its own is not a complete measure of the quality of care at an individual hospital" and until HCFA has "developed additional statistical measures to deal with complex issues, such as severity of illness, we cannot and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals. It should also be stressed that the hospital stay is but one piece of health care management. Many other factors affect the course of an illness, such as preventive health care measures, accessibility of medical care, patient compliance with prescribed regimens, appropriateness of patient workup and diagnosis co-morbidities, timeliness of hospital admission, severity of illness, social factors and personal health care, many of which are unrelated to the patient's hospital care. Readers should be cautioned that the smaller the number of admissions for each category, the less reliable are the statistics, as the impact of random variation of outcomes in

individual cases is greater. Verification of the data is limited since it is not currently possible for individual hospitals to simulate the output from the model to calculate predicted mortality rates nor verify deaths within 30 days of admission but after discharge. The model for calculating predicted mortality rates is seriously limited in that it has not been validated. Furthermore, anyone reading the information should be reminded that this data applies only to Medicare patients and may not exceed this reference base.

Despite these interpretation cautions and limitations, the HCFA data is helpful to better focus quality assurance activities. In all 17 categories, St. Joseph Hospital & Health Center fell well within the range of predicted mortality rates. We find this particularly encouraging since our hospital serves as the referral center for a seven-county region, is considered the regional trauma center and is the only hospital in our primary service area which accepts patients regardless of their ability to pay.

The positive results for St. Joseph Hospital & Health Center should be credited to our aggressive Quality Assurance program and our dedicated medical, nursing and technical staff members. Every patient's chart receives concurrent and retrospective review by the Quality Assurance department and every patient death is submitted to peer review.

St. Joseph Hospital & Health Center is committed to acquiring state-of-the-art diagnostic technology, improving medical treatment capabilities and recruiting physician specialties as appropriate to fully serve our region.

Sincerely,

Sister Gretchen Kunz
President

sh

TX 442.1

St. Joseph Hospital
of Houston

October 26, 1987

William L. Roper, M.D.
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 20127

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics for Medicare admissions to St. Joseph Hospital from January 1, 1986 to December 31, 1986. Since receiving the report dated September 21, 1987, St. Joseph Hospital staff has reviewed and analyzed the data. Our Medical Records Department has reviewed the report and has found that the majority of the data is accurate; however, it should be noted that it does not reflect the entire Medicare population treated at St. Joseph Hospital. It is very significant to note that the cases listed are those in which the patient died within 30 days of admission to rather than discharge from the hospital.

During calendar year 1986, there were 5,342 Medicare discharges at St. Joseph Hospital. However, the Mortality data summarizes 3,343 admissions which reflect only the final admission of the patient and does not take into account the multiple admissions of many of these chronically ill patients.

St. Joseph is an 840 bed not for profit acute care teaching facility that is part of the Sisters of Charity of the Incarnate Word Health Care System. We are a tertiary care medical center whose mission is to offer care to all people in need, with an emphasis on the indigent and elderly. Many of the Medicare patients included in the statistics are seriously and chronically ill patients who require the special services of our facility including, but not limited to, cancer treatment, open heart surgery, cardiopulmonary treatment, acute and dialysis, rehabilitation, orthopedic surgery, neurological and neurosurgical treatment and critical care. In addition, our Emergency Department as well as the expertise found in our medical staff and the advanced technologies available in our hospital make us a major referral center for this region. Examples of the technology available include: magnetic resonance imaging, lithotripsy, cardiac catheterization and angioplasty, renal dialysis, hyperthermia, radiation oncology, diagnostic and therapeutic endoscopy. St. Joseph Hospital also provides inpatient hospice services in conjunction with the Visiting Nurse Association.

As a nonprofit health care provider, our mission is to offer an environment of hope, healing and peace to all who seek relief in times of birth, sickness and death. Our inner city location with a high proportion of poor and ethnic groups whose medical conditions are worsened by their socioeconomic limitations and their inability to seek care in a timely fashion. In an attempt to serve these people sooner, we have developed a "Lifeline" telephone service between the home-bound infirmed and the hosptial Emergency Department, a Vietnamese and Chinese community health program and a physician referral service to provide information and referral to those in need.

1919 LaBranch □ Houston, Texas □ (713) 757-1000

The medical staff quality assurance program at St. Joseph Hospital performs an ongoing mortality review in all clinical departments for appropriateness of care. Quality assurance and medical staff peer review activities are an integral part of monitoring the health care delivery system at this hospital.

It is to be noted that the overall actual mortality rate is within the predicted range for our hospital. In fact, there is only one diagnostic category in which we exceeded the predicted mortality rate, that being metabolic/electrolyte disturbances. This category includes patients admitted in a state of severe dehydration or malnutrition. Many of these patients had multiple significant medical conditions which contributed to their inability to eat or drink. In this category we had a 33% mortality rate and the range was 12% to 31%. This category had been closely scrutinized and the following is a summary of that analysis.

Of the 43 cases reviewed:

31 patients (72%) were admitted in a critical condition through the emergency room;

22 patients (51.2%) were admitted for supportive terminal care and the family requested that no resuscitative measures be initiated;

24 patients (55.8%) had end stage chronic diseases such as diabetes mellitus, renal failure or metastatic cancer;

11 (25.5%) were in such serious condition upon admission that they expired within 24 hours of admission. The average age of the patients in this category was 76.1 years.

Differences in mortality rates between hospitals should not be interpreted as differences in the quality of care. St. Joseph Hosptial plans to incorporate data from this report into our quality assurance and utilization management program as part of committment to quality care for all our patients.

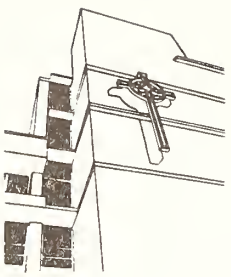
Sincerely,

Sister M. Anastasia Enright

Sister Mary Anastasia Enright
Administrator

Allen C. Bullock, MD

A.C. Bullock, M.D.
Chief of Staff



St. Joseph's
HOSPITAL AND
HEALTH CENTER
820 Clarksville St. • Box 70 • Paris, Texas 75460 • Ph. 214-785-4521

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Data
Medicare Provider #450196

Dear Sir:

We are in receipt of the mortality statistics for the St. Joseph's Hospital and Health Center for 1986. We appreciate the opportunity to review the data and respond.

The mortality rates for all sixteen diagnostic categories have been validated and we find that, with minor exceptions, the data is accurate. Our actual percentage of deaths is within the expected death rates for all diagnostic categories. This is significant for the following reasons:

1. St. Joseph's Hospital and Health Center has been designated by HCFA as a "Regional Referral Center" and therefore receives a great number of more difficult and complicated illnesses from its service area.

2. The service area has a high percentage of persons over seventy-five years of age. Mortality rates for people in this age group are higher than the younger Medicare patients aged sixty-five to seventy-four years.

3. The many specialty services offered by the hospital attract a large number of referrals comprising older, severely ill, and handicapped patients. Among these services are oncology, radiation therapy, home health, hospice, renal dialysis, rehabilitation medicine and thoracic and vascular surgery.

The Medical Staff of St. Joseph's Hospital and Health Center, through its quality assurance program, will continue its review of care provided to each patient treated within this hospital for quality and appropriateness.

Sincerely,

Sister Mary Eustace

Sister Mary Eustace Farrell, FACHE
President

SME/jah

ST. JUDE HOSPITAL

1306 NORTH PARK • BRENHAM, TEXAS 77833 • (409) 836-6101

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sir:

In response to the mortality study provided to St. Jude Hospital, ID #450187 the following comments are submitted for publication with the mortality data. It is noted that of the 87 listed deaths, 20 or approximately 23% of those did not expire at St. Jude Hospital.

The slight increase in percentage over the range of predicted mortality rates can be attributed to the close proximity of a 69 bed skilled nursing facility. This results in increased admissions of patients who become critical in the skilled facility and in turn are admitted to the hospital for care immediately preceeding their death. Of the 67 patients that expired, 37.3% were direct admissions from the nursing home.

Another relevant consideration of the data is the fact that there are two hospitals in the community and it is possible that a patient could have been previously hospitalized at both facilities. To which hospital is the death attributed? Or is there a possibility of double counting?

In reviewing the list of information it is noted that the average age of the deceased is 78 years. This is 3.3 years greater than the total years of life expected at birth for 1984 as published in The World Almanac and Book of Facts 1987.

In conclusion, review of the data by the Utilization Review Committee resulted in agreement that the information provided does not serve to be a justifiable measure of the quality of care. Therefore, the committee felt that the amount of time that could be expended in the further interpretation of the data was not warranted.

Sincerely,

Ben Tobias

Ben Tobias, FACHE
Administrator

BT/lw
Enclosure

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

ST. LUKE'S
Episcopal Hospital

October 22, 1987

Mr. Harvey Brook
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
6325 Security Boulevard
Meadows East Building
Room 2-D-2
Baltimore, Maryland 21207

Dear Mr. Brook:

Please find enclosed the response of St. Luke's Episcopal Hospital in Houston, Texas to the HCFA Mortality Data Release issued in September 1987. Our Medicare Provider Number is 45-0193.

If you have any questions pertaining to this response to the Mortality Data Release, please do not hesitate to contact my office at (713) 791-4041.

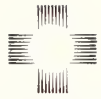
Thank you for allowing us the opportunity to respond to the release of these data.

Sincerely,

John M. Fraser
Senior Vice President

JMF:cb
Enclosures

Texas Medical Center
P.O. Box 20269
Houston, Texas 77225-0269



ST. LUKE'S
Episcopal Hospital

October 22, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Doctor Roper:

Thank you for this opportunity to respond to the release of data on Hospital Mortality Rates for the calendar year 1986.

St. Luke's Episcopal Hospital is a 949 bed general acute care facility affiliated with the Texas Heart Institute, and as such, serves as a regional, national, and international referral center for the medical and surgical treatment of cardiovascular illnesses. We also offer care in the specialties of high-risk obstetrics and gynecology, major orthopedic surgery, neurosurgery, urology, rehabilitative medicine, as well as general surgery and internal medicine.

Due to the nature of our specialized clinical programs, a significant portion of our patients are referred to these services for the treatment of severe disease, after having received preliminary treatment at other institutions. We have found that the extent of these patients' illnesses has steadily increased over the past decade. We anticipate this trend to continue throughout the foreseeable future.

The data included in the Mortality Report have been carefully reviewed by members of the Hospital's Administration, Medical Records Department, Chief of the Medical Staff, and Physician Chairman of the Hospital's Quality of Care Committee. Included in this review was an examination of the care provided to each patient listed in the Report. Our findings have confirmed the severity of illness exhibited by the patients admitted to this facility.

Texas Medical Center
P.O. Box 20269
Houston, Texas 77225-0269
TX 446.1

This pattern was particularly demonstrated in the "low-risk heart disease," "severe chronic heart disease," and "severe acute heart disease" categories as listed in the Report. We have found that the cases categorized as having "low-risk heart disease" consisted of patients, many of whom underwent multiple simultaneous cardiovascular surgical procedures, patients with aortic and/or mitral valve disorders, patients who had previously undergone open heart surgical procedures at this hospital or were transferred directly from other facilities, patients with multiple organ system illnesses, and one patient who had undergone a heart transplant procedure.

The Medical Staff of St. Luke's Episcopal Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding the medical management and overall care provided to that patient. Mortality review is an ongoing process of the Hospital's Quality Assurance Program, and peer review activities serve as an integral part of the monitoring of the quality of health care delivered at this institution. The Hospital's Quality Assurance Program is periodically reviewed by the Joint Commission on Accreditation of Hospitals, which has bestowed on the Hospital its highest accreditation status. We are therefore confident of the quality of medical care provided by our Medical Staff Members to the patients of this Hospital, and take every effort to insure the continued monitoring of the quality and appropriateness of patient care.

Again, thank you for the opportunity to present this response.

Sincerely,

John A. Burdine, M.D.
President and Chief Executive Officer

JAB:cb



October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

RE: Response to HCFA 1986 Mortality Data
For
St. Luke's Lutheran Hospital, San Antonio, Texas
Medicare Provider No. 450681

Dear Dr. Roper:

We appreciate the opportunity to comment on the mortality statistics for 1986 to be released by HCFA.

St. Luke's Lutheran Hospital is a 251-bed acute medical/surgical hospital located in the South Texas Medical Center in San Antonio. Services of the Hospital include a twenty-four hour Emergency Room and an Outpatient Surgical Center. Surgical specialities include Cardio/Thoracic Surgery, General Surgery, Gynecology, Neurosurgery, Ophthalmology, Oral Surgery, Otorinolaryngology, Plastic Surgery, and Urology. Medical specialities include Burn Care, Cardiology, Dermatology, Endocrinology, Gastroenterology, Hematology, Internal Medicine, Nephrology, Neurology, Oncology, Pulmonary Medicine, and Rheumatology.

To further improve our services in the past year, we have added or enhanced many services. In March 1987, a remodeled Coronary Care Unit was opened. It is complimented by a dedicated Cardiac Catheterization Laboratory which began operation in June 1987. The South Texas Magnetic Resonance Imaging Center is currently under constuction at the Hospital.

(512) 690-8600/P.O. BOX 29100/7930 FLOYD CURL /SAN ANTONIO, TEXAS 78229-0100

The Hospital was recently awarded a three-year Certificate of Accreditation by the Joint Commission on Accreditation of Hospitals.

We at St. Luke's Lutheran Hospital are dedicated to quality patient care. In this endeavor, all deaths are reviewed and evaluated through our quality assurance mechanisms. We strive continuously to improve care and services and to decrease mortality as an outcome. This is evident as all diagnostic categories have actual mortality rates within the predicted ranges established by HCFA.

As we reviewed HCFA mortality statistics, discrepancies were noted in the release. Two patient admissions were duplicated in the report, and there were wrong dates of death reported for three patients.

In closing, we would again like to thank you for the opportunity to comment on our mortality statistics.

Sincerely,

Nick H. Kupferle, III
Administrator

Joseph P. Miller, M.D.
Chief of Staff

NHK/JPM:cjl

TX 447.1

St. MARY HOSPITAL
P.O. BOX 3696 • PORT ARTHUR, TEXAS 77643-3696 • 409/985-7431

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Attention: HSQ-148-GNC
P. O. Box 26676
Baltimore, MD 21201

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics for calendar year 1986 prior to public disclosure. Our Assistant Administrator and Director of Medical Records have reviewed the report and they find that the majority of the data is accurate, however, it does not take into consideration the entire Medicare population treated by our facility. Our Chief of Staff has also reviewed a synopsis of medical records of the patients reported and agrees that the report, although limited, is basically accurate.

Considering the advanced average age of 75 years of persons listed as low risk chronic and acute heart mortalities and the average mortality age of 76.5 years for cancer patients, and the fact that our healthcare facility was listed within the predicted mortality rate, the report reinforces that ours is a facility of high expertise and technological capabilities and is being utilized for these services.

St. Mary Hospital of Port Arthur is a 278 bed nonprofit acute care facility that is part of the Sisters of Charity of the Incarnate Word Health Care System. Our patient population includes a high number of older patients with serious medical and surgical illnesses. We are a full-service medical center whose mission is to offer care to all people in need, with an emphasis on the indigent and elderly. A large number of seriously ill patients and people whose conditions require intensive and continuous care, both inpatient and out, are attracted to our facility by the extensive areas of speciality care offered. Presently ours is the only hospital in our south county region to offer open-heart surgery, neurosurgery and complete kidney dialysis treatment.

In addition, the expertise found in our medical staff and the advanced technologies available in our hospital combine to make us a major referral center for this region. Examples of the technology available include magnetic resonance imaging, a complete cardiac catheterization laboratory and cancer treating technologies.

As a nonprofit health care provider, our mission is to offer an environment of hope, healing and peace to all who seek relief in times of birth, sickness, and death. Port Arthur, Texas, has experienced severe economic losses because of an economic downturn and its dependence on the petrochemical industry. Therefore, a large proportion of the population we serve is financially stressed and these persons often do not seek medical care in a timely fashion. To help these persons and others, we conduct many programs promoting illness and injury prevention, health care and wellness, i.e., outreach programs, exercise programs, lifestyle education, telephone links between the hospital and home-bound infirmed, health awareness fairs, and home health agencies.

The medical staff quality assurance programs at St. Mary Hospital reviews all mortality cases for appropriateness of care. Quality assurance and medical staff peer review activities are an integral part of monitoring the health care delivery system at our hospital.

The differences in mortality rates between hospitals should not be interpreted as differences in the quality of care. Our hospital has incorporated data from this report into our ongoing quality assurance and utilization management program as one of many elements reviewed to maintain and improve the quality of care rendered.

Sincerely,

Sister Edith Judge

Sister Edith Judge
Administrator

SEJ/RS/rm

TX 448.1

ST. MARY OF THE PLAINS HOSPITAL
A Sisters of St. Joseph of Orange Corporation

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
HHH Building
200 Independence Avenue, S.W.
Room 314-G
Washington, D.C. 20201

Dear Doctor Roper:

We appreciate the opportunity to respond to the mortality information recently provided us regarding St. Mary of the Plains Hospital.

St. Mary is a 356-bed comprehensive acute care facility. We have a fully equipped 9-bed emergency department completely equipped to handle major trauma which serves as the receiving center for local emergencies as well as our Flight for Life emergency helicopter program. St. Mary offers surgical, medical and coronary intensive care units for adults, as well as two specialty units equipped and staffed to provide intensive care services for children and newborns. Two cardiac catheterization laboratories and two open heart surgical suites demonstrate our commitment to provide state of the art care for coronary patients. Additionally, we have a unit specializing in care for cancer patients as well as a unit for patients requiring orthopedic surgery. While St. Mary provides routine medical and surgical care for Lubbock residents, we also serve as a regional referral center for specialty services in West Texas and Eastern New Mexico. Since a significant number of our admissions are transfers from nursing homes and hospitals in outlying communities, our hospital typically treats more severely ill patients than other comparable community hospitals.

The Director of Medical Records has validated that, with minor exceptions, the mortality information provided by your office is reasonably accurate. The board of trustees and medical staff at St. Mary conduct mortality reviews of every patient who expires at this facility. This review is in conjunction with our ongoing process of quality assurance. Peer review activities are also an integral part of the monitoring of the quality of care provided at our hospital. Our actual mortality rate of only eight percent, compared to a predicted range of seven to 14

percent, indicates that this internal ongoing review program positively impacts the management of patient care.

While we appreciate the fact that the model used for release of this information has taken more factors into account than in the past, we take specific issue with the failure to adequately include weighting for severity of a patient's illness. For example, in reviewing the data regarding mortality in the sepsis category, it is our finding that seventy percent of these patients had multiple complications or disease processes. Additionally, sixty percent of these patients were transferred from other health care facilities as a result of the degree of severity of the patients' illness. Ninety percent of the patients were diagnosed as having system-wide infections at the time of admission. Thirty percent of these patients died within 24 hours of admission, further evidencing the severity of their illness at the time they arrived at St. Mary Hospital. As you proceed with publication of mortality data, it would be useful if additional factors such as those noted above were properly included in your model.

We appreciate this opportunity to respond to the data that you have provided us. We would encourage you to emphasize, as you release this information to the public, its limited use in determining quality of care provided at hospitals.

Sincerely,

James P. Houser
Executive Vice President

JPH/ma

St. Mary's Hospital
Galveston

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to respond to the mortality statistics generated by HCFA for St. Mary's Hospital for Calendar Year 1986.

The Hospital and Medical Staff leadership have reviewed the data submitted by HCFA and are pleased that the actual mortality rate for each diagnostic category was well within the range of predicted mortality rates.

Quality Assurance and Medical Staff Peer Review activities are an integral part of monitoring the health care delivery system at this hospital. The medical staff reviews all mortality cases for appropriateness of care. We plan to incorporate data from HCFA's report into ongoing quality assurance and utilization management review programs.

Sincerely,

Keith B. Reed, Jr.
Administrator

KBR/ad

404 St. Mary's Boulevard, Galveston, Texas 77550, (409) 763-5301
A member of Sisters of Charity of the Incarnate World Health Care System, Houston, Texas

ST PAUL
MEDICAL CENTER

5909 Harry Hines Blvd.
Dallas, Texas 75235
(214) 879-1000

CERTIFIED MAIL
RETURN RECEIPT

Anthony L. Bunker
President

October 23, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
HSQ-148-GNC
P.O. Box 26676
Baltimore, Maryland 21201

Re: Hospital Specific Report Concerning Mortality Data for 1986

Dear Dr. Roper:

We respectfully request that the following information be attached to the Health Care Financing Administration (HCFA) Hospital Specific Report concerning mortality for Medicare patients treated at St. Paul Medical Center during 1986.

St. Paul Medical Center (SPMC) is an acute care general hospital, licensed to operate 600 beds. SPMC is accredited by the Joint Commission on Accreditation of Health Care Organizations. As indicated by our high Medicare Case Mix Index, SPMC serves many patients with serious medical and surgical disease. We are a a full service hospital with some 32 recognized medical specialty disciplines, such as: medical, surgical and radiation cancer programs; treatment of cardiovascular diseases, including open heart surgery; bone and joint surgery; and kidney dialysis, among others.

SPMC is a teaching hospital closely affiliated with the University of Texas Southwestern Medical Center in Dallas. Many of the medical school faculty members hold clinical practice privileges in SPMC. This has led us to develop some highly sophisticated inpatient services, particularly otorhinolaryngology and neurosurgery.

Our Board of Directors established a comprehensive Quality Assurance Program in order to maintain the highest standards of patient care. A detailed review of the medical record of each patient who dies at SPMC is already a key feature of our Quality Assurance Program.

The hospital specific mortality data for the sixteen (16) diagnostic categories developed by HCFA has been carefully reviewed by representatives of the SPMC Administration and Medical Staff, Administrative Director of Medical Records, and the Vice President in charge of Utilization Review and Quality Assurance Programs. Apart from a few minor and inconsequential details, such as a small variance in the reported age of patients, and an occasional discrepancy in the dates of admission, our internal records of these patients agree with the data collected by HCFA.

The actual mortality rate for SPMC falls within the range of predicted mortality rates for each diagnostic category. Nevertheless, we have carefully examined the HCFA report in an effort to improve our own analytic techniques. One crucial observation concerns the HCFA technical requirement for designation of the patient's principal diagnosis, which makes little or no provision for differences in severity of illness between individuals or for cause of death. In some cases, this approach appears to lead to a misclassification of patients into diagnostic categories labeled as "high" or "low" risk.

The HCFA model does make some adjustments in the range of predicted mortality based on certain coexisting diseases, age, sex, and previous hospitalization. However, review of SPMC data reveals that these complicating factors do not appear to be utilized by the HCFA model in placing patients in diagnostic categories labeled as high or low risk. For example, in those fatal cases classified by HCFA as low risk heart disease at SPMC, a substantial majority underwent open heart surgical operations while in the hospital. These include patients who were admitted with advanced heart disease for mitral valve replacement surgery. Members of our medical staff do not believe that valvular diseases of this severity should be considered low risk. Furthermore, several of these patients classified as "low risk" had been transferred from other hospitals to SPMC with unstable disease unresponsive to conventional treatment. In such cases, underlying disease has progressed to such a point of exceptional risk for death that it can not be satisfactorily indicated by the broad statistical diagnostic codes utilized in the HCFA model.

Problems of this nature may be unavoidable because the HCFA information was originally collected for use in determining reimbursement levels for hospitals and lends itself poorly to the determination of important scientific issues such as the causes and expectations of death.

Thank you for the opportunity to present this response to the HCFA Mortality Data.

Sincerely,

Anthony L. Bunker
President

cc: Luis Leib, M.D., President
SPMC Medical Staff

Robert L. North, M.D.
SPMC Vice President for Medical Affairs

TX 451.1

SMH

STEPHENS MEMORIAL HOSPITAL
200 SOUTH GENEVA
BRECKENRIDGE, TEXAS 76024

CHARLES R. BALLEW, ADMINISTRATOR TELEPHONE 559-2241

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Roper:

After reviewing the mortality information for Stephens Memorial Hospital, provider #450498, I would like to submit the following corrections concerning the actual causes of death on three of the patients. It should be noted that the diagnosis listed as the cause of death on the mortality report was sometimes actually the principal diagnosis, which is the diagnosis responsible for the patient's admission. The cause of death may not always be the same diagnosis as that on admission. The following are such examples:

ID[redacted] Principal diagnosis: Obstipation. Cause of Death: Carcinoma of lung with cerebral metastasis.

ID[redacted] Principal diagnosis: Dehydration. Cause of Death: Carcinoma of lung.

ID[redacted] Principal diagnosis: COPD Cause of Death: Acute respiratory failure.

Sincerely,

Carla Barnes, L.N.; D.O.N.

Carla Barnes, R.N.
Acting Administrator

Acting Administration

Stonewall Memorial Hospital
DRAWER C (817) 989-3551
ASPERMONT, TEXAS 79502

October 27, 1987

Department of Health and Human Services
William L. Roper, M.D., Administrator
Washington, D.C. 20201

To Whom It May Concern:

We have found one error in the HCFA data related to the discharge and death date.
All cases identified in the actual mortality rates fall in the identified High Risk Category.
We have reviewed each case as it occurs with appropriateness of care supported by sufficient documentation.

Sincerely,

Clara Woods

Clara Woods, Administrator

CW/bc

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Sweeny Community Hospital

305 NORTH McKINNEY ST.
SWEENY, TEXAS 77480

October 21, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Re: Medicare mortality rates
Provider number 450065

Dear Dr. Roper:

Thank you for the opportunity to review and respond to our hospital's mortality rates prior to publication.

Sweeny Community Hospital is a small general medical/surgical hospital licensed for 49 beds. Approximately 45% of our patients are Medicare beneficiaries.

The Medical Records/Utilization Review Committee whose members are two Medical Staff physician members, the Chief Executive Officer, Director of Nursing Service and the Director of Medical Records reviewed the mortality data for our hospital and found it to be accurate as far as can be determined. In reviewing the deaths it was found that three patients died of terminal illnesses after being admitted to the hospital for another condition, consequently placing those deaths in an inappropriate medical category. Also, five patients expired after discharge from the hospital. In reviewing these records, the patients had reached maximum hospital benefit at the time of discharge. The results of the review was shared with the Medical Staff as a whole.

We are very proud of the quality of medical care we deliver at our hospital. We are accredited by the Joint Commission on the Accreditation of Healthcare Organizations and continually strive to improve the quality of care provided by our staff. Our medical staff on a monthly basis reviews every death regarding medical management and overall care. We feel the mortality rates for our hospital help to demonstrate the quality of care the medical staff provides.

Sincerely,

Alan Graham
Interim Chief Executive Officer

dfm

AMI Terrell Community Hospital, Inc.

October 16, 1987

William L. Roper, M.D.,Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

The following information for Terrell Community Hospital is to be attached to the Hospital Mortality Data Release Report for 1986 prior to public disclosure.

Terrell Community Hospital is a 73 bed acute care facility, whose case mix includes many patients with major medical and surgical illnesses. We are a full service medical center offering care in general medicine and surgery areas.

The Executive Staff at Terrell Community Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital.

The hospital specific mortality data reported by HCFA has been carefully reviewed by: the hospital administrators, President of the Medical Staff, Physician Chairman of the Utilization Review Committee, Director of Utilization Review & Quality Assurance and the Director of Medical Records. We are pleased that Terrell Community Hospital has no category where the actual rate exceeded the predicted rate, although mortality rate is certainly not the only indicator of quality care, we feel that it is a very important one at this facility.

Thank you for the opportunity to present this response.

Sincerely,

Larry Graham
Executive Director

1551 Highway 34 South Terrell Texas 75160 214 563-7611

AMI Texarkana Community Hospital

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Provider #450703

Dear Sir:

Thank you for the opportunity to provide input on the mortality statistics for the period between January 1, 1986 and December 31, 1986.

The facility's actual mortality rate falls within the range of predicted mortality rates in all categories. However, the death percentage statistics are greatly affected by the sample size - the impact of one death in a small sample size can be significant. The reported eleven (11) deaths post-discharge have not been verified.

Our hospital medical staff monitors every death in our facility on an on-going basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards. The Medical Staff of Texarkana Community Hospital will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient.

Thank you for the opportunity to present this response.

Sincerely,

Jerry R. Kincade
Executive Director

JRK:pw

TEXOMA MEDICAL CENTER

October 26, 1987

William F. Roper, M.D.
Administrator, HCFA
Department of Health and Human Services
Washington, D.C. 20201

Re: Medicare Provider No. 45-0324

Dear Dr. Roper:

This letter is pursuant to the public release of mortality rates for Medicare patients and we request that the following comments be included with the release of Texoma Medical Center's data.

Texoma Medical Center is a 294 bed general acute care facility, certified by the Joint Commission on Accreditation of Hospitals. Specialty care unique to Texoma Medical Center in our area in 1986 included a kidney dialysis unit, cobalt therapy for cancer treatment, neurosurgery, heart catheterization, and substance abuse treatment.

Texoma Medical Center personnel verified the patient names given in the release and feels that the data is correct; however, due to the lack of any data concerning severity of illness we feel the mortality data cannot be used as a measure of the quality of care provided at Texoma Medical Center or any other health care facility.

As has been the practice for many years, medical staff committees at Texoma Medical Center utilize a monitoring system to provide feedback on an ongoing basis to assure high quality care standards. Physician committees monitor, review, and evaluate every death record for quality assessment.

Thank you for the opportunity to present this response.

Sincerely,

Mike Mayes, FACHE
President

MM/ks

P.O. Box 890 • Denison, Texas 75020 • (214) 465-2313

Institute for Immunological Disorders

7407 North Freeway Houston, Texas 77076
713-691-3531

October 27, 1987

Dr. William Roper, Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

The Institute for Immunological Disorders is appreciative of this opportunity to comment on the mortality data to be published by HCFA later this year.

The 22 cases reported in the data occurred during the conversion of this facility from Citizens General Hospital to the Institute for Immunological Disorders and, therefore, might not be representative of the usual activity of Citizens General Hospital.

Since September 1, 1987, this facility has been exclusively devoted to research and treatment of persons with AIDS, and as such, these reported data would not be representative of the Institute's patient activity.

Sincerely,

Clive R. Waxman
Executive Director

81/CRW:es

Larry L. Mathis
President
Chief Executive Officer

Methodist

The
Methodist
Hospital

6565 Fannin
Houston, Texas 77030
METHHOSPHOU or 774143
(713) 790-3366

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
200 Independence Ave SW
Room 309G
Washington, D.C. 20201

Dear Dr. Roper:

The Methodist Hospital appreciates the opportunity to comment on the Medicare mortality data scheduled for publication and release by the Health Care Financing Administration later this year.

The Methodist Hospital is a 1218 bed, general acute care facility, located in Houston's Texas Medical Center. As the primary private adult teaching hospital for the Baylor College of Medicine, Methodist receives patients from all 50 states and more than 70 foreign countries. The Hospital's status as a major tertiary referral center is exemplified by its recent approval as a Medicare heart transplant center and our accreditation as a teaching hospital cancer center by the American College of Surgeons.

I would like to first address the accuracy of the institution - specific mortality data generated by HCFA for The Methodist Hospital and then offer some comments about the data as it applies to this institution.

Mortality Data Accuracy

Statisticians in our Medical Records Department have carefully reviewed the mortality data sent to us by the Health Care Financing Administration (HCFA). With only minor discrepancies, we have been able to verify all the data with the exception of the number of total Medicare cases reported.

The HCFA data credit The Methodist Hospital with 6,551 Medicare cases during 1986. As we understand the model, this number should include all Medicare beneficiaries discharged from the Hospital in 1986, excluding all but the last admission of patients with multiple hospitalizations during the year. Using those assumptions, our records indicate that the number of total cases for The Methodist Hospital should be 8,661, 2,110 or 32% more than

reported by HCFA. Applying this number of cases to the mortality rate formula, Methodist's overall mortality rate drops from the reported 7% to 5%.

The data as presented contain one serious inaccuracy which could be misleading to the readers of the published document. The Hospital's overall mortality rate is listed with the caption "All Causes". Cause of death is not a part of this analysis. HCFA's data are grouped according to diagnoses, the reasons for these patients' last hospital admissions. In many cases, the event which causes a patient's death will be unrelated to the diagnosis. Hospitals generally do not report cause of death to HCFA, as it can only be accurately determined by autopsy.

Comments on the Data

The data we received indicate that The Methodist Hospital's mortality rates were within the ranges predicted by HCFA for each of the 16 diagnostic categories and for the overall measure listed as "All Causes".

In the category "Low-risk heart disease", our actual mortality rate is 6%, the upper limit of the predicted range of 3-6%. This category includes diagnoses of chronic and acute ischemic heart disease and angina pectoris. These are among the most common diagnoses of candidates for coronary artery bypass and valve replacement surgery, making the words "low risk" misleading.

The Methodist Hospital is one of the nation's leading referral centers for cardiovascular disease. Of all 1986 Medicare patients with diagnoses in the category, 62% live outside Harris County, where the Hospital is located. Forty-nine percent of all our Medicare patients come from outside the county. Many of the patients referred here for treatment are too severely ill or have conditions too complicated to be managed in a community hospital.

Of the 63 deaths listed in the "low-risk heart disease" category, 40 or 63% underwent a cardiovascular surgical procedure. Eleven of these patients had more than one additional diagnosis, a factor which adds significantly to the complexity of these cases. The HCFA model fails to allow for these additional complications as well as others such as the patient's general state of health, the severity of his disease, and any socioeconomic factors potentially influencing the patient's chance of death.

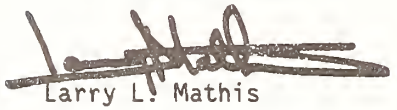
Summary

Since it last published mortality data, HCFA has made significant improvement in the process of releasing mortality information to the public. The advance notice and ability to comment on the data are appropriate and very much appreciated; however, the complexity of this information and the lack of supporting documentation to appropriately qualify it make it virtually impossible for the general public to comprehend and thereby evaluate provider "quality."

Recipients of the mortality data release should keep two important points in mind when comparing hospital mortality rates. First, the HCFA model does not adequately account for the many complicating factors present in the patients treated by the nation's referral centers. Because facilities like The Methodist Hospital treat the most severe and complex cases within each diagnostic category, our mortality rates can be expected to be generally higher than those of non-referral centers; however, this clearly is no indication that the quality of care is lesser than that of facilities with lower rates.

Most importantly, it must be emphasized that mortality rates alone cannot be assumed to relate directly to quality of care. At best, these data should be used to encourage hospitals to develop thorough programs in quality assurance. In The Methodist Hospital's program, every inpatient death is reviewed by the attending physician's peers. In addition, many other aspects of the process of care are reviewed and evaluated regularly to ensure provision of high quality patient care and services.

Sincerely,



Larry L. Mathis
President
Chief Executive Officer

LLM:spm

THE UNIVERSITY OF TEXAS
HEALTH CENTER
AT TYLER

Office of the Director

P.O. Box 2003, Tyler, TX 75710
Phone: (214) 877-3451

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, DC 20201

Dear Doctor Roper:

Thank you for the opportunity to comment on the mortality data compiled on Medicare patients admitted to our facility in 1986. Although the data shows our hospital to be within the predictable ranges, the data has been carefully reviewed by our Medical Records Department and those in charge of monitoring the quality of care at this State acute care referral center.

The University of Texas Health Center at Tyler is a comprehensive tertiary referral center having a primary focus upon cardiopulmonary diseases. It is mandated by the Texas Legislature to serve as a primary statewide referral institution to citizens of Texas who are afflicted with these diseases. The hospital receives patients upon referral from physicians in its own ambulatory care service and from other physicians, hospitals and government agencies,as well as self-referrals.

Most referrals which are admitted are cases requiring specialized diagnosis and treatment. These patients often are acutely ill upon admission and often require longer-than-average intensive care. Pulmonary disease and heart disease often are life-threatening, and in the case of indigents, these conditions often are exacerbated because indigents seldom have obtained routine care that could have prevented acute episodes.

The result of this additional review produced the following pertinent information:

- Of the 193 cases reviewed, 182 cases were identified as having at least one additional complicating condition. Of the 182 cases, 124 had two or more complicating conditions. These facts alone substantiate the coexistence of other diseases and in many cases such as those admitted with urologic disease and metabolic disease, the cause of death was related to cardiopulmonary arrest secondary to severe obstructive lung disease.

- The chronic nature of our patients can further be illustrated by the fact that of the 193 cases reviewed, 133 had been admitted to the U.T. Health Center on two or more occasions with one patient falling in the 60th to 69th admission category.

- In the category of cancer, the number of deaths equates to 26% of all deaths. This is a reflection of the fact that our oncology service represents one of our major service centers of our facility. Additionally, many of the patients in this category were diagnosed as having cancer of the lung with metastasis and/or other organ failure at the time of admission.

The U.T. Health Center has several internal mechanisms for evaluating the performance of its physicians and ancillary departments. The quality of care is also monitored by external organizations such as the Joint Commission on Accreditation of Hospitals which as given the institution high marks.

A Utilization Review/Quality Assurance Committee, headed by the chairman of the pathology department and co-chaired by the chief of staff, conducts an intensive review of all aspects of patient care, including all mortality cases. This committee is subdivided into focus groups -- such as surgery, medicine and blood transfusion -- which provide close monitoring of the quality of care.

Thank you for the opportunity to respond to this report.

Sincerely,

George A. Hurst

George A. Hurst, M.D.
Director

gh

FROM: The Woodlands Community Hospital
(Hospital)
9250 Pinecroft
The Woodlands, Texas 77380, Texas
(City)

SUBJECT: Hospital Authorization to Release HCFA Mortality Data to AHA, THA, DFWHC, GHHC

As announced in the August 17, 1987 Federal Register, the Health Care Financing Administration (HCFA) plans to release in December, 1987, information about hospitals' overall post-admission mortality rates and specific mortality rates for specific medical conditions. Future informational releases are planned by HCFA as part of its continued review of the quality of care provided by hospitals participating in the Medicare program.

The release of hospital mortality statistics or other quality of care data and measurements raises questions for individual hospitals and the hospital industry generally. In order to assist the hospital industry in interpreting such data releases, and responding to the public and press, the The Woodlands Community Hospital is authorizing the release of statistical data (either specific to this hospital or aggregrate data issued by HCFA) to the American Hospital Association (AHA), the Texas Hospital Association (THA), the Dallas/Ft. Worth Hospital Council (DFWHC), and the Greater Houston Hospital Council (GHHC).

This release also allows AHA to provide any studies or interpretation of such data or information releases to the THA, DFWHC and GHHC.

Signed Pat Peyton

Position Administrator

Date September 22, 1987

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

TOMBALL REGIONAL HOSPITAL

October 22, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on our hospital's mortality rates for Medicare patients during 1986 as compiled and published by HCFA.

Tomball Regional Hospital is a 140-bed community-based acute care facility whose case mix includes many patients with major medical and surgical illness. The medical staff at Tomball Regional Hospital, as part of our overall quality assurance and peer review activities, reviews the medical record of every patient who expires at Tomball Regional Hospital in regard to the medical management and overall care they received. The medical staff and hospital personnel have been successful in maintaining the high level of care required by the standards of the Joint Commission on Accreditation of Hospitals.

Tomball Regional Hospital, as the provider of choice for acutely ill patients from three (3) local long-term extended care facilities and other Medicare-eligible residents, normally has a Medicare patient population which approximates forty-five percent (45%) of our total patients. These patients usually have a high acuity level of illness with multiple diagnoses and complications resulting from advancing age.

Tomball Regional Hospital's mortality rate as published is at the lower end of the predicted mortality range. The following statistical information may be helpful to potential readers:

- Eighty-nine percent (89%) of the reported deaths were recorded in diagnoses related groups which HCFA considers high risk admissions.

- Of the remaining eleven percent (11%) which were classified by HCFA in other diagnoses related groups, eighty-six percent (86%) were in patients age 76 or greater.

- In seventy-six percent (76%) of the total deaths reported during which the Medicare patient was hospitalized, either the patient and/or the family had requested "no code." This indicated that the patient and/or the family was aware that the patient's condition

605 Holderrieth • Tomball, Texas • 77375 • (713) 351-1623
Located in the Tomball Regional Medical Center

was incurable and that death was imminent.

- In over half of the deaths reported after the patient had been discharged from the hospital, either the patient and/or their family had requested "no code" during the admission period reported in the study.

The medical staff and personnel of Tomball Regional Hospital will continue to monitor and review the quality and appropriateness of care provided to all patients we have the privilege to serve. Again, thank you for the opportunity to present this response.

Sincerely,

Robert F. Schaper
Executive Director

RFS/amh

Tri-City Community Hospital

Highway 97, Box 189
Jourdanton, Texas 78026
512/769-3515

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Medicare Provider #450165

Dear Dr. Roper:

As requested by your letter of September 21, 1987, the following comments are provided concerning the 1986 Medicare patient mortality data:

a. Tri-City Community, a short term, acute care hospital, is licensed by the state of Texas for 65 beds and currently operates 30. The facility is the only hospital serving the 29,000 residents of rural Atascosa County. It is located approximately 28 miles from the nearest hospital. Tri-City operates a level III Emergency Department, and provides round the clock services in respiratory therapy, laboratory including blood bank, diagnostic radiology and electrocardiagram services. One general medical-surgical nursing unit cares for all categories of patients.

b. The Medicare patient mortality data for 1986 was reviewed by the medical staff, administration and key members of the hospital staff. The data presented on the 59 death cases was verified and the few inaccuracies noted were the dates of death of three cases and age of the deceased patient in one case. Our hospital experienced 804 discharges for Medicare patients in 1986 and the 39 patients who expired while a patient represented 4.85% of total discharges. Death was anticipated in almost one half of the hospital death cases since 46.15% of those patient charts contained Do-Not-Resusiate (DNR) orders. Of the non-DNR patients, many cases were transferred to tertiary care hospitals for further care. In the aggregate, the mortality statistics do not adaquately reflect the mobidity of those patients. Almost 51% were admitted from nursing homes and most patients presented with multiple chronic conditions, including Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Artherosclerotic Cardiovascular Disease including Stroke, while others were in advanced stages of cancer.

HEALTHSTAR*

c. Tri-City Community Hospital is fully accredited by the Joint Commission for the Accreditation of Healthcare Organizations. As part of the on-going extensive program of quality assurance, all medical staff and hospital patient care activities are monitored and evaluated monthly. Patterns of deviation from accepted standards of care and practice are analyzed and the providers concerned are proctored to insure compliance. In addition, our hospital is evaluated by the Peer Review Organization (PRO) for Texas, the Texas Medical Foundation, which has been recently cited by a national consumer group as one of the two best PRO programs in the nation.

We believe it is imperative that HCFA emphasizes that their 1986 mortality statistics are not a complete or adequate measure of the quality of care provided in this facility.

Thank you for your cooperation and understanding.

Sincerely,

Dean P. Lemmers
Administrator

DPL:ag

TRINITY
MEDICAL
CENTER

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Re: Hospital I.D. Number 450730

Dear Sirs:

We have reviewed deaths of all Medicare patients admitted to Trinity Medical Center for the year 1986. Two-hundred ninety three (293) Medicare patients have been admitted during this period. Of these, there were 24 deaths; 15 deaths were the expected outcome at the time of the patient's admission and 9 were probable outcomes.

The quality of care of these patients, as reviewed by peers, was appropriate.

Sincerely,

Steve Corbeil
Associate Administrator

SC/sb

4343 North Josey Lane, Carrollton, Texas 75010 214/492-1010
A National Medical Enterprises Health Care Facility

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS JOINT MILITARY MEDICAL COMMAND — SAN ANTONIO (ATC)
WILFORD HALL USAF MEDICAL CENTER
LACKLAND AIR FORCE BASE TX 78236-5300

REPLY TO
ATTN OF SG-3

20 October 1987

SUBJECT Medicare Patient Mortality Information, Medical Center #45081F

TO Department of Health & Human Services
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

1. Reference your 21 September 1987 letter regarding Medicare patient mortality data. The information is misleading for the following reasons:

a. Wilford Hall USAF Medical Center is a Department of Defense worldwide referral medical center located in San Antonio, Texas, and one of only three level one emergency trauma centers in the city. Although serving primarily active duty and retired military personnel and their dependents, Wilford Hall receives numerous civilian emergency patients via Emergency Medical Service (EMS) delivery. During 1986, we averaged approximately 3,663 Emergency Room (ER) visits each month. The six patients identified in your study represent approximately .01364% of the total emergency room workload for 1986.

b. The six Medicare patients identified were treated as civilian emergency patients in our emergency room during 1986. They were billed for treatment according to Air Force Regulation 168-6, Persons Authorized Medical Care. Also, these cases required identification to HQ USAF for Medicare reimbursement.

2. The following comments summarize each case:

a. Patient [redacted] - 58 year old male arrived by EMS transfer with sinus tachycardia and decreasing pulse. This patient recently was released from a local civilian medical facility following a case of pneumonia. Cause of death was probable primary cardiac event with electromechanical dissociation.

b. Patient [redacted] 80 year old female arrived by EMS transfer after full arrest and resuscitation. Final diagnosis indicated acute cardiac failure with apparent underlying cardiovascular disease, chronic obstructive pulmonary disease.

c. Patient [redacted] 93 year old female arrived by EMS transfer for injuries sustained in a motor vehicle accident. While receiving treatment, developed a bradycardia with a nodal escape rhythm which deteriorated to an agonal rhythm.

d. Patient [redacted] - 78 year old male arrived with acute shortness of breath. Patient subsequently died of cardiac arrest, probably acute myocardial infarction with congestive heart failure and asystole.

e. Patient [redacted] 78 year old male arrived by EMS transfer. Cause of death was massive left intracerebral hemorrhage, probably secondary to hypertension.

f. Patient [redacted] - 72 year old male arrived by EMS transfer. He had a history of ascites and cirrhosis, secondary to chronic alcohol abuse, peptic ulcer disease, and borderline diabetes mellitus. The patient subsequently underwent sinus bradycardia and asystole and died.

3. The statistical data presented identifies non-DoD Medicare eligible civilian emergencies and in no way takes into consideration the many Medicare eligible patients with military healthcare eligibility that we treat each year.

FOR THE COMMANDER

Robert L. Collier

ROBERT L. COLLIER
Colonel, USAF, MSC
Administrator

Provider: Valley Baptist Medical Center
Medicare Provider Number: 450033
RE: Health Care Financing Administration Mortality Statistics
for Valley Baptist Medical Center

Thank you for the opportunity to respond to the release of hospital specific mortality rates for calendar year 1986.

Valley Baptist Medical Center recognizes the need to assure that hospitals and doctors are providing quality care. However, death statistics may not be the best criteria to judge whether or not quality care is being provided.

In the current release of mortality data, there are many different kinds of diseases placed into one of sixteen diagnostic categories. Besides a patient's principal diagnosis, it is our understanding that other factors such as the patient's sex and age were also considered in predicting a hospital's mortality rate. One important factor which was not considered was the patient's severity of illness.

The death rates at Valley Baptist Medical Center are within the predicted ranges for each of the sixteen diagnostic categories. There is no statistically significant difference between the hospital's actual mortality rate and the hospital's predicted mortality rate.

The internal reviews of the Medical and Dental staff at Valley Baptist Medical Center have consistently shown that quality care is being rendered. Our findings are confirmed by the Joint Commission on Accreditation of Health Care Organizations and the Texas Medical Foundation, both of which are independent organizations concerned with monitoring the quality of care provided by hospitals and doctors.

A separate review of the Medicare mortality statistics was initiated upon receipt of the data approximately three weeks ago. This review is ongoing, but significant findings to date for two of the diagnostic categories are indicative of findings overall.

Cerebrovascular Accidents - Each of the Medicare patients who expired in this category had two or more of the following conditions:

(1) Age greater than 80 years
(2) Hemorrhage into the brain
(3) Multiple and severe coexisting diseases
(4) Coexisting malignant disease

In no instance does the information in the medical record indicate anything but the fact that a fatal outcome was inevitable.

Provider: Valley Baptist Medical Center
Medicare Provider Number: 450033

Severe Acute Heart Disease - In each of the cases which were reviewed, the medical record shows the patient was in an acute, severe, critical condition and death was an unavoidable outcome, regardless of the aggressive treatment performed at Valley Baptist Medical Center.

Over 25 percent of the patients were actually in shock or had experienced cardiac arrest prior to transfer to the Valley Baptist Emergency Room. Several other patients arrived in the hospital's Emergency Room in a moribund state and did not recover after heroic efforts by the hospital and Harlingen's Emergency Medical Service.

We hope that more accurate indicators of quality can be developed in the future and applied consistently and fairly to all providers of health care services. Until that time, we would caution those who would attempt to make unsubstantiated judgments regarding the quality of care performed by a provider based upon the provider's Medicare mortality statistics.

Sincerely,

Joseph C. Dougherty, M.D.
Chairman, Utilization Review Committee

HCA Village Oaks Regional Hospital

September 28, 1987

Department of Health & Human Services
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Comments on the HCFA Mortality data Hospital ID Number 450733

Listed below are errors identified in the data prepared by HCFA.

Patient ID Number (HIC)	Surname (1st 6 ltrs)	Error	Correction
[redacted]	[redacted]	principal diagnosis 1560	1990
		age 62	61
		age 64	65
		age 69	67
		age 92	72
		date of admit 09/06/86	03/09/87
		date of discharge 09/20/86	05/02/87
		date of death 09/15/86	05/02/87
		age 77	86
		diagnostic category HM	HS
		date of admit 12/19/86	12/30/86
		date of discharge 12/25/86	01/08/87
		principal diagnosis 4280	42769
		principal procedure none	3772

The data used by HCFA indicates that a total of 41 Medicare patients admitted to the hospital died within 30 days of admission. Of these, 37 died while still a patient of the hospital, while 4 died after discharge. One patient was admitted and expired in the hospital in 1987, rather than in 1986. This would reduce the number of patients to 40 total.

The hospital's actual mortality rate did not fall outside of the range of the predicted mortality rate in any of the diagnostic categories.

Sincerely,

Emil B. Friesenhahn

Emil B. Friesenhahn
Administrative Resident

12412 Judson Road
San Antonio, Texas 78233
Telephone: (512) 650-4949
A Subsidiary of HCA The Healthcare Company

WAGNER GENERAL HOSPITAL

DONALD G. HYETT, CHIEF OPERATING OFFICER

310 Green
P. O. Box 859

Phone (512) 972-2511
Palacios, Texas 77465

450246

Wagner General Hospital's patient cliental is made up of approximately 65% Medicare aged patients, who are usually more sick classification of patients than younger patients.

Each mortality occuring in Wagner General is reviewed by the Medical Staff at its monthly Medical Staff meeting to see if the patient was treated appropriately and to see if deaths were avoidable. This review insures that any problems are addressed and solutions are reached to correct any problems.

The Medical Staff operates as a committee of the whole in monitoring all quality of care rendered in all areas of the hospital. This includes medical, surgical, pediatric, obstetrical, newborn, anesthesia and emergency room patients. This is done to insure that Wagner General gives the patient optimal patient care at all times.

If at any time, someone has a question, the hospital stands ready to answer your question. The Administrator, Donald Hyett, and any of the Medical Staff members are happy to serve your needs.

WAGNER GENERAL HOSPITAL EXPERIENCE--MORTALITY REPORTING 1986

SUMMARY

All deaths in 1986 in all categories fell below the range of predicted mortality rates.

Of the 134 Medicare patients admitted, there were 18 deaths for 13% mortality rate wich is also below the range of predicted mortality rates.

(14 of the 18 deaths were in Wagner General Hospital and 4 were outside Wagner General.)

Average age was 83 years.

Age 65-70	1 patient
Age 71-79	4 patients
Age 80-89	11 patients
Age 90+	2 patients
TOTAL	18 patients

		HIGH RISK	LOW RISK
CE:	Cerebrovascular accidents (1)	CE: 1	GI: 1
GI:	Gastrointestinal disease (1)	HS: 1	
HM:	Severe chronic heart disease (4)	HM: 4	UN: 3
HS:	Severe acute heart disease (1)	ME: 2	
ME:	Metabolic/Electrolyte disturbance (2)	PN: 6	
PN:	Pulmonary disease (6)		
UN:	All other categories (3)		

14=78% of deaths were in the high risk category.

Donald G. Hyett, Administrator
hd
10-22-87

Walls Regional Hospital

October 21, 1987

Dr. William R. Roper
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

This letter is in response to the Medicare Mortality Statistics for 1986. We appreciate the opportunity to review this data and to submit our comments. We will be using the data to improve our comprehensive, on-going quality assurance activities. Walls Regional Hospital, Harris Methodist Cleburne, is a 112-bed acute care facility. As the only hospital in the county, our mission to provide quality care to the citizens is extensive.

Although our Medicare mortality rates are well within the predicted ranges for each category, we would like to share some observations of the information with you.

65% of the Medicare patients who died were over 80 years old at the time of admission.

42% of the patients were documented as having a terminal illness.

40% of the patients or their families had requested that life sustaining measures such as resuscitation (CPR) not be performed.

39% of the patients were transferred from nursing homes.

23% of the patients were comatose at the time of arrival at the hospital.

Our highest Medicare death rates were experienced in Sepsis and Severe Acute Heart Disease. The total number of patients admitted with Sepsis was very low (7 cases). Of the four deaths in this category, three patients were comatose at the time of transfer from nursing homes. The average age for these four patients who died was 83 years.

A member of
Harris Methodist Health System

Hwy 67 West 201 Walls Drive/Cleburne, Texas 76031/817-641-2551

With regard to severe acute heart disease, Medicare's data indicates that 22 of 50 patients died. One patient was transferred to a Fort Worth facility and died there according to our records. Another patient was transferred to a Veterans Hosptial and died there. Of the remaining 20 deaths, 3 were comatose, 4 had been advised that their illnesses were terminal and, at the family or patient's request, potentially life saving measures were not initiated.

Every chart in your report has been scrutinized for data that can be used to improve the quality of care that we deliver.

The medical staff and the administration of Walls Regional Hospital have been and will continue to be dedicated to reviewing the quality and appropriateness of medical care to our patients.

Sincerely,

Thomas P. Jose
Group Vice President
Harris Methodist Health System

TPJ/jf

HCA West Houston Medical Center

October 12, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Sir:

We have reviewed the mortality information provided by the Health Care Financing Administration and have determined that all such Medicare patients were hospitalized at West Houston Medical Center in 1986. Our records show that, among the thirty-five beneficiaries that HCFA indicates died within thirty days of admission, ten such patients were, in fact, discharged alive. We have no knowledge of the cause of death of these ten patients.

Please find enclosed a listing of those ten patients discharged alive from this institution for your information. If you have any questions in this regard, please contact us at your convenience.

Sincerely,

Joseph O. Lewis, II
Assistant Administrator

JOL/lam

attachment

12141 Richmond Avenue
Houston, Texas 77082
Telephone (713) 558-3444
A Subsidiary of HCA The Healthcare Company

FROM: WEST HOUSTON MEDICAL CENTER
(Hospital)

HOUSTON, Texas
(City)

SUBJECT: Hospital Authorization to Release HCFA Mortality Data to AHA, THA, DFWHC, GHHC

As announced in the August 17, 1987 Federal Register, the Health Care Financing Administration (HCFA) plans to release in December, 1987, information about hospitals' overall post-admission mortality rates and specific mortality rates for specific medical conditions. Future informational releases are planned by HCFA as part of its continued review of the quality of care provided by hospitals participating in the Medicare program.

The release of hospital mortality statistics or other quality of care data and measurements raises questions for individual hospitals and the hospital industry generally. In order to assist the hospital industry in interpreting such data releases, and responding to the public and press, the West Houston Med. Cntr. Hospital is authorizing the release of statistical data (either specific to this hospital or aggregrate data issued by HCFA) to the American Hospital Association (AHA), the Texas Hospital Association (THA), the Dallas/Ft. Worth Hospital Council (DFWHC), and the Greater Houston Hospital Council (GHHC).

This release also allows AHA to provide any studies or interpretation of such data or information releases to the THA, DFWHC and GHHC.

Signed J.O. Lewis, II

J.O. Lewis, II
Position Assistant Administrator

Date October 13, 1987

WILSON
MEMORIAL
HOSPITAL

COMMENTS ON THE HCFA MORTALITY DATA
WILSON MEMORIAL HOSPITAL, FLORESVILLE, TEXAS 78114

I have received and reviewed HCFA's packet of information on our Hospital Mortality Rates.

Even though our actual experiences are well within HCFA's Predicted Rates, I am not convinced that this sort of statistical analysis can be used to measure hospitals performances..

The model may accurately and reliably reflect the relationship between a small amount of patient characteristics and the risk of death, but it does not reliably predict hospital mortality rates. It fails to consider a wide range of factors with a significant impact on mortality. Examples: include but not limited to; the patients general health status, the stage of the patients illness, the patients psychological condition and family support.

In areas similar to ours, with shortage of nursing home beds, patients with chronic degenerative conditions are usually admitted to hospitals shortly before death. This situation may inflate death rate figures.

Rural hospitals specifically admit higher medicare mix than urban hospitals. These patients are usually older medicare recipients with chronic conditions or co-morbid conditions.

In smaller, rural hospitals the number of admissions in certain categories is usually not large enough to make an accurate representation or comparisons with HCFA rates.

It is impossible to evaluate the percentage of patients dying after discharge who were in fact alive, as information concerning death is not included in the patients medical record. (Patient could have died in an accident or non-related medical death)

HCFA's model has obviously not been validated. As noted above,

WILSON
COUNTY
MEMORIAL
HOSPITAL
DISTRICT
1301 Hospital Blvd
Floresville, TX 78114
512-393-3122
512-635-8470 (San Antonio)

deviations from the predicted mortality rate could indicate some problem with the quality of care in some hospital, but it could also reflect the exclusions from the model, of significant factors influencing the risk of death. Statistical analysis can do no more than screen for further reviews. Quality judgements can only be made after reviewing the information contained in patients medical record.

Pete Delgado
Executive Director

WILSON N. JONES
MEMORIAL
HOSPITAL

October 26, 1987

William L. Roper, M.D.
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C., 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of HCFA mortality data. We believe that it is essential to explain the statistics clearly to the public and to repeat your statement that the information cannot be used "by itself to make judgements about the quality of care in an individual hospital or to make comparisons among hospitals."

Wilson N. Jones Memorial Hospital is a 227 bed acute care hospital which has maintained an open admission policy for the past 59 years. The hospital admits all patients, regardless of financial reserves or previous health history. It is in a rural area of Texas, Grayson County, which has the highest percentage of persons over 65 in the state.

It is the only area hospital to operate separate intensive care units - a 10-bed surgical intensive care unit and a 10-bed medical intensive care unit. The high volume of cardiac patients served justifies our telemetry unit, soon to expand to 37 beds. WNJ has opened a cardiac catheterization lab and offers magnetic resonance imaging services, both of which lead patients and physicians to utilize this hospital rather than transfer patients to Dallas. In addition, the hospital's emergency department is the recognized leader in treating major trauma and industrial accidents. Our patients are sicker when they reach us since many pass up other facilities for our specialized care.

TX 505

500 N HIGHLAND • P O BOX 1258 • PHONE (214) 893-4611 • SHERMAN, TEXAS 75090

A total of 2,525 Medicare patients were admitted to Wilson N. Jones Memorial Hospital during 1986. 1,565 patients were included in the HCFA study because their last admission for 1986 was to WNJ. 112 patients died in the hospital within 30 days of their admission to the hospital. 35 patients died after being released from the hospital. 32 of the 35 were high risk patients with a "grim and unstable" prognosis, returning to nursing homes with instructions not to resuscitate. The average age of all Medicare patients who died was 79.55 years.

The mortality rate for Medicare patients at Wilson N. Jones Memorial Hospital was 9.39%, rounded up to 10% by HCFA, in the low range of predicted mortality rate.

The hospital has difficulty in determining the methodology used by HCFA to determine the "predicted mortality rates." It does not include the clinical characteristics necessary to make an adjustment based on the severity of illness, in part, because no one is sure how "severity" should be measured. HCFA has acknowledged that this is the greatest flaw in their model.

Wilson N. Jones Memorial Hospital takes a positive approach to the issue of quality care. We approach the issue in several different directions which we believe to be of relevance to our patients and physicians. Proper admissions, appropriate care plans and successful outcomes of care are all reviewed constantly by nursing, quality assurance, medical staff and other departments within the hospital.

The quality assurance program in effect for the past several years has set up a system to identify both efficient and problematic areas within and between all departments in the hospital. All departments are required to participate and all recognize the clear-cut goals of top quality patient care, efficent utilization of skilled professional staff and equipment, and cost efficiency. Quality standards at Wilson N. Jones Memorial Hospital are applied to all patient care, young and old, minor day surgery, obstetrics or terminal illness. Any indication of a quality problem leads to prompt investigation and follow through.

Although our rates are within acceptable limits, our view is that mortality rates cannot clearly measure quality, but rather, that they confuse the consumer. Mortality rates are a valid indicator to guide peer review - physicians monitoring physician care. Quality is better measured through peer review on a case by case basis.

The hospital does generate its own mortality statistics for internal quality indicators. Each death, regardless of age, is reviewed by the department chairman of the pertinent medical specialty. All cases of unexpected death are reviewed thoroughly at the medical staff department meeting.

While WNJ is in a good position in the HCFA release, the use of Medicare data only, without elaboration on the methodology, does not fully reflect a complete image of patient care at this or any hospital.

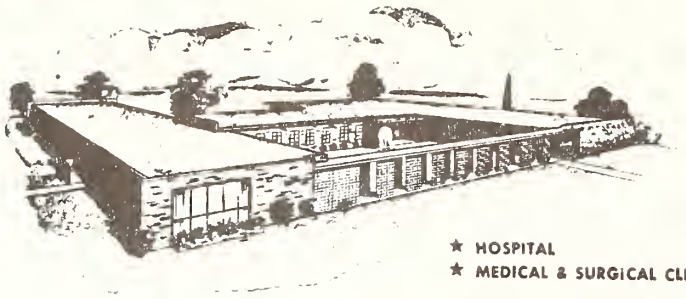
In conclusion, our medical staff and both the American Hospital Asociation and the Joint Commision on the Accreditation of Hospitals are evaluating other methods of measuring the quality of patient care. The WNJ medical staff is devising its own quality monitors and is developing some original data on quality issues.

WNJ looks forward to the results of these investigations and the associated benefits for our patients.

Sincerely,

Harry F. Barnes

Harry F. Barnes, FACHE
Administrator



★ HOSPITAL
★ MEDICAL & SURGICAL CLINIC

Winter Garden
Medical Center, Inc.

BOX 29 • DILLEY, TEXAS – 78017
PHONE 512-965-1551

October 20, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Review
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

I have just finished reviewing the mortality information (see attached copy) and must admit its gross stupidity tops them all. I do not know who is responsible for this obvious waste of manpower and common sense, but I strongly suggest that the responsible party be immediately laughed at in public. Additionally, I should like to make three kind observations:

1) To identify only the last hospital admissions for the year (per individual patient), appears to be an obvious attempt to inflate the mortality rate of the hospital, or in other words, to make the public read what the bureaucrats want them to read, rather than accurate information.

2) The "sophisticated statistical technique" is so much rubbish. A seventh grader knows this statistical sample is not valid. The actual cause of death in many cases is not even the same as the principal diagnosis which is used in every case.

3) Included in our list of deaths was a patient admitted here but transferred to another facility where she expired. I am curious if this admission and death was counted against both facilities.

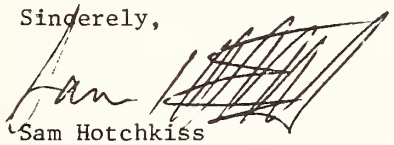
The "sophisticated statistical technique" as exhibited in numbers 1, 2, and 3 above show this study for what it really is -- a complete sham.

I am not sure for what purpose this was done, but we will take no part in this study. If these erroneous figures are published anywhere, we

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

shall take whatever legal staps must be taken, even though the costs will be prohibitive. This is the last straw!

Sincerely,

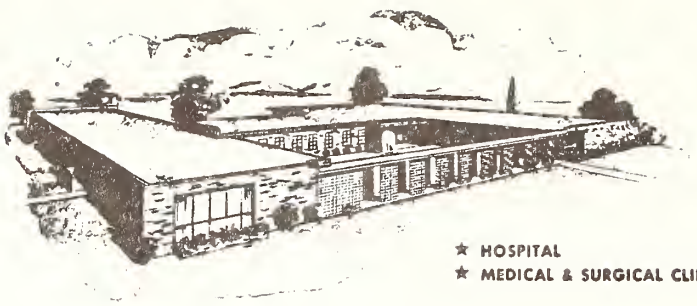


Sam Hotchkiss
Administrator
Medicare Provider Number 450077

SH:jsb

P.S. -- When all Medicare admissions for the time frame are used in the "sample" our overall mortality rate is 8% instead of 18% as shown in your report. -- SH

cc--Senator Llbyd Bentsen
Senator Phil Gramm
Representative E. "Kika" de la Garza



★ HOSPITAL
★ MEDICAL & SURGICAL CLINIC

Winter Garden
Medical Center, Inc.

BOX 29 • DILLEY, TEXAS – 78017
PHONE 512-965-1551

October 19, 1987

William L. Roper, M. D., Adminstrator
Health Care Financing Administration
Health Standards & Quality Review
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

After consultation with other members of our staff I would like to respond to your letter of September 21, 1987, to our hospital administrator. Regarding the mortality information, I should like to point out that there is no place on the billing form (UB82) to report the cause of death of the patient, therefore, the mortality figures are completely inaccurate since they reflect only the cause of admission to the hospital. One patient in the report was transferred to another hospital and died in that hospital. Are all transfer patients counted as deaths in both the admitting and the referral hospital?

We also note that there were more admisstions to our hospital for the various classes than are reflected in your figures. This also increases the already inaccurate rates.

Very truly yours,

Richard H. Hood, M. D.
Chief of Staff
Hospital Provider Number 450077

RHH:jsb
cc - Senator Lloyd Bentsen
Senator Phil Gramm
Representative E. "Kika" de la Garza

Wylie Community Hospital

801 W. HWY. 78 • P.O. BOX 1500 • WYLIE, TEXAS 75098 • (214) 442-5414

William Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

October 23, 1987

REF: Medicare Provider # 450691

Dear Dr. Roper,

In response to the Health Care Financing Administration's mortality data recently released to us, there are some areas of contention that we would like to address.

A) The total number of cases attributed to Wylie Community Hospital is 139, with total medicare admissions for 1986 being 253. There exists a wide discrepancy in "all causes" cases. It therefore becomes impossible for us to evaluate this data without disclosure of the 139 cases' identifying information.

B) With the exception of one of the 15 diagnostic categories listed, our actual mortality rate per category averaged far below the predicted range. Yet, our actual mortality rate for "all causes" leaned toward the high range of predicted rates. The deviation in these figures would tend to invalidate these statistics.

Our hospital studies in regard to your data indicate 20 in-house deaths and 7 occurring within 30 days post-discharge. To address these 7 deaths, each of these patients were released to nursing home facilities for further care and treatment. The 20 deaths occurring in Wylie Community Hospital during 1986 show, from our investigation, to be over 60% nursing home patients with long standing chronic disease processes in well over 90% of the cases. Upon review, we find the average age at the time of death to be 81. With information derived from insurance actuary tables, most patients with acute or chronic illnesses at age 81 would fall into an almost 100% mortality rate.

Your attention in reviewing these details is greatly appreciated.

Yours truly,

Peggy McCollum, R.N.
Assistant Administrator

YETTIE KERSTING MEMORIAL HOSPITAL
1353 NORTH TRAVIS
LIBERTY, TEXAS 77575
409/336-7316

Richard D. Arnold – Administrator
John Pegues, M.D. – Chief of Staff

Board of Directors:
Edward B. Pickett – President
A.J. Finley – Vice President
Helen Dishongh – Secretary
Dr. S.M. Elliott – Member
R.B. Evans – Member
Dr. C.W. Castle – Member
Dr. John Pegues – Member
George Richardson – Member
Elton Williams – Member
W.B. Williamson – Member
Brunella Yarbrough – Member

October 23, 1987

William L.Roper,M.D.,Administrator
Health Care Financing Administration
P.O.Box 26684
Baltimore,Maryland 21207

Re: Hospital Mortality Information
Yettie Kersting Memorial Hospital
Liberty, Texas 77575
450417 Calendar year 1986

Dear Dr.Roper:

Yettie Kersting Memorial Hospital is a 49 bed general, short stay, primary care hospital located in Liberty, Texas. The hospital is established as a County Hospital Authority with a mission to provide access to health care for members of the Liberty County community without regard to religious preference, ethnic background or ability to pay. Affiliation is maintained with secondary and tertiary health care facilities in Houston,Galveston and Beaumont to assure access to appropriate levels of care. Patients are transferred to and from the appropriate facilities within this network in accordance with patient preference and care requirements.

The HCFA mortality report for this hospital for 1986 was reviewed by members of the hospital's Medical Records Department, Administration, Medical Staff and Board of Directors. It has been the practice of this hospital in association with its accreditation with JCAH to monitor the quality of care rendered to all patients on an on-going basis. All deaths are reviewed and appropriateness of care determinations are made on a monthly basis by members of the medical staff and hospital personnel.

An analysis of the date presented in the HCFA mortality report showed that 27 of the 53 deaths (50.9%) occurred within 72 hours of admission and nine of the 53 deaths (17%) occurred within 24 hours of admission. The mortality rate of 11 of the 14 categories presented or 76% of the deaths included within these categories were consistent with or below the mean of the predicted mortality range. Only one category reporting one death and one patient within that category exceeded the predicted mortality rates range.

It is the continuing goal of the directors,employees and Medical Staff of this hospital to render quality care to the patients we serve, consistent with the established mission of this organization. Every effort is made to maintain the confidence of the public that is so vital to the well being of the individuals we serve. Any effort by any organization that would undermine this confidence and trust in an unwarranted manner is detrimental to the health and safety of the citizens of this county and should be recognized as such.

Sincerely,

Richard D. Arnold

Richard Arnold
Administrator

TX 511

Utah

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALLEN MEMORIAL HOSP MOAB UT 84532	UT-5 *	74	14	4-20	2	100	4-92	1	100	3-99	1	0	0-97	4	25	1-74	2	0	2-90	2	0	0-95	14	7	4-45
ALTA VIEW HOSPITAL SANOY UT 84070	UT-6 *	274	11	6-16	16	19	3-42	9	33	11-67	6	17	2-63	9	11	3-54	11	27	17-70	4	25	2-75	31	19	9-38 8
AMERICAN FORK HOSP AMERICAN FORK UT 84003	UT-7	505	10	7-15	22	14	7-42	16	19	9-51	14	21	4-45	26	19	8-39	21	33	19-59	14	29	5-49	64	23	9-30
ASHLEY VALLEY MEDICAL CENT VERNAL UT 84078	UT-8 *	189	9	7-18	2	50	3-91	4	75	10-85	4	25	2-75	14	7	7-50	5	60	11-81	3	0	0-87	21	10	6-40
BEAR RIVER VALLEY HOSP TREMONTON UT 84337	UT-9	87	7	5-20	1	0	1-97	2	0	1-89	5	0	2-69	4	50	3-76	3	67	6-87	1	0	0-99	17	12	5-42
BEAVER VALLEY HOSPITAL BEAVER UT 84713	UT-10 *	87	14	7-23	3	67	2-82	1	100	0-97	1	0	0-99	8	25	4-59	5	60	10-80	3	0	1-82	15	7	5-45
BRIGHAM CITY COMMUNITY HOS BRIGHAM CITY UT 84302	UT-11 *	319	11	7-17	17	24	9-51	8	25	7-64	11	18	3-50	12	33	5-50	8	38	12-71	17	29	8-48	36	11	8-35
CASTLEVIEW HOSPITAL PRICE UT 84501	UT-12 *	550	12	8-16	22	41	14-52	15	33	13-58	14	7	3-43	18	22	8-45	20	30	21-62	27	22	6-37	46	11	10-35
CENTRAL VALLEY MEDICAL CTR NEPHI UT 84648	UT-13 *	100	11	7-21	2	50	0-89	3	0	4-84	4	25	1-74	8	38	7-63	3	33	5-85	8	0	3-58	11	36	7-55
COTTONWOOD HOSPITAL MURRAY UT 84107	UT-14	1448	12	7-14	101	21	14-34	71	27	17-38	27	30	6-37	43	42	12-37	56	34	25-51	11	18	2-48	107	25	11-28
DELTA COMMUNITY MEDICAL CE DELTA UT 84624	UT-15 *	67	7	7-24	3	67	10-91	.	.		.	.		3	0	1-81	2	0	5-93	2	50	2-90	9	22	7-61
DIXIE MEDICAL CENTER ST. GEORGE UT 84770	UT-16	1279	8	7-14	108	16	14-34	42	26	17-44	35	3	5-30	49	20	11-34	50	24	25-52	12	8	3-48	85	21	9-27
DOXEY HATCH MEDICAL CENTER SALT LAKE CITY UT 84119	UT-17 *	62	23	5-23	6	83	5-69	1	100	0-97	2	50	0-92	3	0	2-81	.	.		6	0	2-64	6	67	9-74
DUCHESNE COUNTY HOSPITAL ROOSEVELT UT 84066	UT-18 *	161	13	7-19	.	.		5	40	5-73	3	33	1-81	14	21	6-48	5	60	10-80	8	25	3-58	27	15	8-38 8
FILLMORE COMM MED CTR FILLMORE UT 84631	UT-19 *	65	22	12-33	1	100	7-98	2	0	5-94	6	50	3-65	6	33	8-73	7	57	16-79	4	25	1-74	8	25	7-64
GARFIELD MEM HOSP PANGUITCH UT 84759	UT-20 *	108	6	4-17	2	100	4-92	6	0	7-71	3	33	0-83	3	0	1-81	4	0	5-79	1	0	0-99	13	0	3-45
GUNNISON VALLEY HOSPITAL GUNNISON UT 84634	UT-21 *	156	13	9-22	7	86	10-72	4	50	4-77	8	50	7-65	10	20	6-56	10	30	15-70	3	0	1-81	22	5	6-38 8
HOLY CROSS HOSPITAL SALT LAKE CITY UT 84102	UT-22	2518	10	7-14	130	10	15-33	65	43	19-42	51	20	8-32	126	20	14-29	88	38	29-50	64	22	9-33	186	16	12-25
HUMANA HOSPITAL DAVIS NORT LAYTON UT 84041	UT-23	534	10	8-16	28	39	10-42	18	33	12-53	8	25	5-61	32	28	11-40	22	27	21-61	19	0	5-41	51	14	9-32
KANE CO HOSP KANAB UT 84741	UT-24 *	74	15	7-24	1	100	0-98	9	33	8-63	2	50	0-91	4	0	3-75	1	0	1-97	6	17	4-67	6	17	1-62
LAKEVIEW HOSPITAL BOUNTIFUL UT 84010	UT-25 *	630	12	8-16	40	8	8-35	31	19	15-47	14	21	3-43	32	22	10-38	34	41	25-58	19	5	4-41	64	22	9-30
LATTER-DAY SAINTS HOSPITAL SALT LAKE CITY UT 84143	UT-26 *	4203	8	7-13	412	11	15-29	88	35	20-40	75	17	7-27	111	20	14-31	152	29	30-47	77	12	7-29	208	18	14-28
LOGAN HOSPITAL LOGAN UT 84321	UT-27 *	1067	9	8-15	79	11	12-34	39	33	14-42	40	15	6-32	35	17	11-38	45	33	27-57	34	15	6-35	85	13	11-30
MCKAY-DEE HOSPITAL CENTER OGDEN UT 84402	UT-28 *	2382	9	7-13	120	23	16-35	72	29	18-40	49	16	7-30	94	28	15-33	83	27	25-47	31	10	10-41	136	24	13-29
MILFORD VALLEY MEM HOSP MILFORD UT 84751	UT-29 *	76	4	4-19	.	.		1	100	0-97	4	25	1-74	2	0	1-89	2	50	5-94	2	0	0-91	9	0	2-51
MONUMENT VALLEY HOSP MONUMENT VALLEY UT 84536	UT-30 *	40	13	6-30	1	0	1-97	1	0	0-97	.	.		.	.		1	100	1-97	4	25	1-74	15	20	7-48

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALLEN MEMORIAL HOSP MOAB UT 84532	1	100	0-97	.	.		.	.		.	.		10	10	0-50	1	0	0-100	2	0	0-100	12	8	0-45	4	0	0-99
ALTA VIEW HOSPITAL SANDY UT 84070	.	.		.	.		9	0	1-50	.	.		37	3	1-18	11	18	1-45	7	0	0-100	20	15	0-28	22	0	0-50
AMERICAN FORK HOSP AMERICAN FORK UT 84003	6	0	2-66	8	13	8-66	15	0	1-36	1	0	0-100	85	2	1-11	26	4	0-28	8	0	0-98	42	5	1-18	34	3	0-21
ASHLEY VALLEY MEDICAL CENT VERNAL UT 84078	2	50	1-90	5	60	5-76	5	20	0-69	.	.		35	3	1-19	12	0	0-43	1	0	0-100	13	0	0-39	13	0	0-64
BEAR RIVER VALLEY HOSP TREMONTON UT 84337	.	.		.	.		.	.		.	.		13	0	1-39	2	0	0-98	1	0	0-100	9	0	0-54	2	0	0-100
BEAVER VALLEY HOSPITAL BEAVER UT 84713	4	0	7-83	.	.		3	33	1-81	.	.		15	7	0-37	.	.		.	.		3	0	0-90	1	0	0-99
BRIGHAM CITY COMMUNITY HOS BRIGHAM CITY UT 84302	5	0	2-71	9	22	10-67	17	12	2-36	.	.		38	5	1-19	14	0	0-42	4	0	0-100	18	0	0-31	34	3	0-22
CASTLEVIEW HOSPITAL PRICE UT 84501	4	50	5-80	10	50	10-64	14	7	1-39	1	0	0-100	94	7	2-13	15	0	0-37	2	0	0-100	50	2	1-16	27	11	1-22
CENTRAL VALLEY MEDICAL CTR NEPHI UT 84648	.			1	0	1-97	.	.		.	.		7	0	0-70	4	0	0-86	.	.		10	0	0-48	2	0	0-100
COTTONWOOD HOSPITAL MURRAY UT 84107	8	25	5-64	17	35	13-57	49	12	3-20	36	3	0-69	210	4	2-9	74	0	0-14	28	4	0-50	101	4	1-10	111	2	0-7
DELTA COMMUNITY MEDICAL CE DELTA UT 84624	1	0	0-100	.	.		2	0	0-95	.	.		12	0	0-42	2	0	0-90	.	.		6	0	0-72	3	0	0-92
DIXIE MEDICAL CENTER ST. GEORGE UT 84770	11	27	9-63	5	40	12-83	38	5	2-21	1	0	0-100	200	2	2-9	56	7	0-16	22	0	0-92	99	2	2-11	124	0	0-7
DOKEY HATCH MEDICAL CENTER SALT LAKE CITY UT 84119	.			1	0	0-97				.			.			1	0	0-100				3	67	0-84	9	0	0-91
DUCHESNE COUNTY HOSPITAL ROOSEVELT UT 84066	2	0	2-90	2	50	3-92	1	0	0-99				19	0	2-52	4	25	0-89	.	.		17	6	1-32	9	0	0-69
FILLMORE COMM MED CTR FILLMORE UT 84631	1	0	2-99	2	50	6-94	.	.		.	.		4	0	0-77							5	0	0-89	1	0	0-100
GARFIELD MEM HOSP PANGUITCH UT 84759	1	0	0-97				2	50	0-84	1	0	0-100	25	0	0-25	3	0	0-98	1	0	0-100	7	14	0-68	3	0	0-100
GUNNISON VALLEY HOSPITAL GUNNISON UT 84634	2	0	1-90	2	50	3-91	1	0	0-100	.	.		11	9	0-44	2	0	0-100	.	.		12	0	0-46	10	0	0-86
HOLY CROSS HOSPITAL SALT LAKE CITY UT 84102	26	8	7-46	17	24	18-64	97	8	4-17	99	0	0-12	226	7	2-9	91	5	1-13	25	0	0-73	198	4	2-9	171	1	0-5
HUMANA HOSPITAL DAVIS NORT LAYTON UT 84041	5	40	11-83	5	40	9-80	12	0	2-43	1	0	0-100	64	3	1-13	36	0	0-21	7	0	0-100	35	3	1-19	29	3	0-27
KANE CO HOSP KANAB UT 84741	3	67	3-84	.	.		1	0	0-100	.	.		10	0	0-50	1	0	0-99	1	0	0-100	5	0	0-83	4	25	1-74
LAKEVIEW HOSPITAL BOUNTIFUL UT 84010	7	43	2-63	11	27	13-56	23	17	2-29	.	.		82	9	2-13	45	0	0-18	16	0	0-98	32	9	1-21	49	2	0-15
LATTER-DAY SAINTS HOSPITAL SALT LAKE CITY UT 84143	39	10	7-40	24	38	23-53	88	10	4-18	49	0	0-34	457	5	3-8	247	2	1-10	63	0	0-48	540	4	3-7	406	1	0-4
LOGAN HOSPITAL LOGAN UT 84321	9	11	7-65	4	0	4-78	49	4	3-21	1	0	0-100	134	2	2-10	56	7	0-15	17	0	0-97	54	4	1-15	103	1	0-8
MCKAY-DEE HOSPITAL CENTER OGDEN UT 84402	18	28	7-50	6	17	9-75	61	7	3-19	2	0	0-100	275	5	2-8	67	3	1-13	37	0	0-76	255	4	2-8	204	0	0-5
MILFORD VALLEY MEM HOSP MILFORD UT 84751	2	0	0-90	1	0	1-97	.	.		.	.		5	0	0-85	2	0	0-98	1	0	0-98	4	0	0-87	7	0	0-89
MONUMENT VALLEY HOSP MONUMENT VALLEY UT 84536	.	.		1	0	1-97	.	.		.	.		4	0	0-64	.	.		.	.		3	0	0-83	.	.	

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																							
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MOUNTAINVIEW HOSP PAYSON UT 84651	UT-31 *	699	10	6-13	35	20	9-37	26	23	15-50	10	10	4-53	22	18	7-40	14	50	17-64	17	0	3-41	49	27	9-33
OREM COMMUNITY HOSP OREM UT 84057	UT-32 *	42	5	1-19	.	.		.	.		1	0	0-99	.	.		.	.		.	.		1	0	0-97
PIONEER VALLEY HOSPITAL WEST VALLEY CITY UT 84120	UT-33	627	12	7-15	25	16	11-46	24	38	13-49	11	0	2-48	28	18	9-40	33	45	20-53	20	15	4-40	63	25	8-28 8
SAN JUAN HOSP MONTICELLO UT 84535	UT-34 *	78	19	7-24	2	50	1-89	2	50	1-89	4	0	2-75	9	11	4-55	1	0	1-97	8	13	1-56	15	60	7-49
SANPETE HOSPITAL MOUNT PLEASANT UT 84647	UT-35 *	104	11	7-22	1	100	2-98	1	0	0-97	1	0	0-99	6	17	3-65	11	45	15-68	4	0	0-78	11	9	4-51
SEVIER VALLEY HOSP RICHFIELD UT 84701	UT-36 *	250	14	8-18	4	25	2-75	11	45	8-57	12	25	3-47	17	35	8-48	15	33	19-65	3	0	0-84	37	14	8-34
ST BENEDICT'S HOSPITAL OGDEN UT 84403	UT-37	1193	12	9-16	97	34	21-42	36	44	17-47	24	4	7-40	40	20	12-38	41	46	25-56	37	3	9-38	83	22	12-30
ST MARKS HOSP SALT LAKE CITY UT 84124	UT-38 *	2037	10	6-13	115	23	15-34	61	30	18-42	43	16	10-37	48	29	14-38	65	43	26-50	25	36	8-42	113	14	11-28
TOOELE VALLEY REGIONAL MED TOOELE UT 84074	UT-39 *	124	14	8-22	9	22	7-62	3	0	3-82	5	0	1-68	12	17	7-53	7	71	14-77	3	0	0-83	18	17	7-44
UNIVERSITY OF UTAH HOSP SALT LAKE CITY UT 84123	UT-40	1425	8	7-14	153	15	20-38	33	36	14-44	12	17	6-52	35	11	12-40	25	36	18-55	21	14	4-39	62	15	10-31
UTAH VALLEY REGIONAL MED C PROVO UT 84604	UT-41 *	2458	12	8-14	164	26	16-33	101	22	18-37	51	27	9-33	83	23	14-32	91	23	27-48	32	19	7-37	156	25	14-29
VALLEY VIEW MEDICAL CENTER CEDAR CITY UT 84720	UT-42	224	11	5-15	6	33	7-72	5	40	4-71	4	0	1-74	9	22	5-57	8	25	13-72	8	0	3-58	22	23	7-42
WASATCH COUNTY HOSPITAL HEBER CITY UT 84032	UT-43	171	18	8-20	4	50	1-74	7	57	9-70	5	0	1-68	9	11	6-59	9	33	12-68	6	83	7-72	30	27	9-38

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MOUNTAINVIEW HOSP PAYSON UT 84651	3	0	1-82	10	40	14-70	27	19	3-29	1	0	0-100	104	5	1-11	33	3	0-23	8	0	0-100	42	10	1-17	125	1	0-7
OREM COMMUNITY HOSP OREM UT 84057							4	25	0-79				4	0	0-97	3	0	0-95	1	0	0-100	1	0	0-100	10	0	0-38
PIONEER VALLEY HOSPITAL WEST VALLEY CITY UT 84120	6	17	1-65				10	0	1-47				70	7	1-13	25	8	1-26	2	0	0-100	42	7	1-18	52	0	0-15
SAN JUAN HOSP MONTICELLO UT 84535				2	100	2-90							5	0	0-76	4	0	0-75				3	0	0-95	5	0	0-99
SANPETE HOSPITAL MOUNT PLEASANT UT 84647	2	0	1-90	1	100	2-98	5	0	0-71				11	0	0-44	1	0	0-100	1	0	0-100	8	0	0-60	9	11	0-65
SEVIER VALLEY HOSP RICHFIELD UT 84701	1	100	1-97	2	50	8-95							35	6	1-19	5	0	0-71	5	0	0-93	16	0	0-35	13	0	0-42
ST BENEDICT'S HOSPITAL OGDEN UT 84403	15	20	7-53	9	56	17-76	39	23	3-24	3	0	0-100	165	3	2-13	55	2	1-16	10	0	0-98	68	1	2-13	145	2	0-6
ST MARKS HOSP SALT LAKE CITY UT 84124	18	6	6-49	17	24	15-59	75	14	4-18	9	0	0-100	268	3	2-8	70	1	1-14	25	0	0-91	259	3	2-7	266	2	0-4
TOOELE VALLEY REGIONAL MED TOOELE UT 84074	3	0	1-82	1	0	0-97							16	0	1-34	4	25	0-91				11	18	1-43	1	0	0-100
UNIVERSITY OF UTAH HOSP SALT LAKE CITY UT 84123	20	5	3-44	10	10	10-55	19	11	1-32	45	4	0-27	64	1	2-14	37	5	1-20	20	0	0-80	73	8	2-14	137	1	0-6
UTAH VALLEY REGIONAL MED C PROVO UT 84604	5	20	1-71	27	33	23-51	66	17	4-29	7	0	0-100	320	7	2-8	97	7	1-13	37	0	0-60	263	4	2-8	248	2	1-5 8
VALLEY VIEW MEDICAL CENTER CEDAR CITY UT 84720	1	0	0-98				7	29	1-57	1	100	0-100	33	3	0-20	10	0	0-57	4	0	0-100	18	6	0-31	40	3	0-23
WASATCH COUNTY HOSPITAL HEBER CITY UT 84032	2	0	0-91	1	0	1-98	1	0	0-97				21	5	0-28	4	0	0-76	2	0	0-100	16	0	0-31	4	25	0-100

*Written Comments Not Submitted.

AMERICAN FORK HOSPITAL

170 North 1100 East, American Fork, Utah 84003, (801) 756-6001
Craig M. Smedley, Administrator

October 22, 1987

William L. Roper, M.D.
Dept. of Health & Human Resources
Health Care Financing Administration
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for giving us the opportunity to respond to the mortality information generated from American Fork Hospital prior to publishing the data. Even though our mortality rate fell within the predicted range, we desire to respond to the survey.

Of the 49 deaths associated with our hospital, 24, or 49%, occurred inside the hospital while 25. 51%, happened within 30 days of discharge. The deaths that occurred within the hospital are reviewed by a physician committee to evaluate the care given and determine whether there were any untimely deaths. Findings of the committed showed that care given to all 24 individuals was appropriate.

Regarding the individuals that died outside the hospital, there are many questions that need to be raised. Did the physician discharge inappropriately? What was the expected outcome of the patient? Was the cause of death the same as the discharge diagnosis? Were all lifesaving efforts given to the patient at the time of death as would be provided by the hospital staff? Did the patient have a living will requesting "Do Not Resuscitate" orders? Did age of the patient affect the outcome? Is the hospital responsible for the patient after discharge when they have no control over the patient? These questions need to be answered before you include death after discharge in your data with the assumption that the hospital is responsible for the deaths.

At American Fork Hospital, patient's discharged from the hospital have recovered from an acute episode or illness and only after the physician feels comfortable in discharging the patient. As the hospital reviews the care given through the several quality assurance committees, there has been very few patients that have been discharged too early or inappropriately.

Patients can be grouped into two classes of patients--those that have a chronic condition such as cancer, multiple sclerosis, chronic obstructive pulmonary disease (COPD), etc.; and those that have acute conditions such as respiratory arrest, cardiac arrest, etc. The expected outcome of a person that has a chronic condition is that their illness will eventually kill them. The

death may occur in the hospital, thirty days after the hospital discharge, or two years after the hospital discharge. It is hard to believe the hospital is responsible for the cause of death when a person dies after suffering through a chronic illness. There were 17 of the 25 people who died outside the hospital that had one or more chronic conditions including cancer, chronic obstructive pulmonary disease, renal failure, chronic heart failure, and multiple sclerosis.

The remaining 8 people died from an acute condition. Seven of the eight deaths had a different hospital discharge diagnosis than the cause of death. These individuals may have been in a nursing home with "Do Not Resuscitate" orders, at home without lifesaving resources, or had a living will requesting "Do Not Resuscitate" orders. We find it hard to accept the blame for death when these patients were out of our responsibility or control. The one patient that died from an acute condition did have the same discharge diagnosis as cause of death, but died 13 days later.

The type of data that you are providing the public needs to be explained in more depth because it can be very misleading.

Thank you for listening.

Sincerely,

Craig M. Smedley

Craig M. Smedley
Administrator

js

cc: David Wirthlin
Ken Johnson
Bobbi Ingram
Troy Carlton

HOSPITAL = 460039 BEAR RIVER VALLEY HOSP TREMONTON UT

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	87	7 %	5 TO 20 %
CA - CANCER	1	0 %	1 TO 97 %
CE - CEREBROVASCULAR ACCIDENTS	2	0 %	1 TO 89 %
GC - GASTROINTESTINAL CATASTROPHES	5	0 %	2 TO 69 %
GI - GASTROINTESTINAL DISEASE	13	0 %	1 TO 39 %
GU - UROLOGIC DISEASE	2	0 %	0 TO 98 %
GY - GYNECOLOGIC DISEASE	1	0 %	0 TO 100 %
HL - LOW-RISK HEART DISEASE	9	0 %	0 TO 54 %
HM - SEVERE CHRONIC HEART DISEASE	4	50 %	3 TO 76 %
HS - SEVERE ACUTE HEART DISEASE	3	67 %	6 TO 87 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	1	0 %	0 TO 99 %
OP - ORTHOPEDIC DISORDERS	2	0 %	0 TO 100 %
PN - PULMONARY DISEASE	17	12 %	5 TO 42 %

UT 9

I THINK THAT THERE ARE INHERENT DANGERS IN PUBLISHING EPIDIMIOLOGIC DATA FOR CONSUMPTION BY THE GENERAL PUBLIC. THE QUESTION OF RATE VS INCIDENCE IS NOT ADDRESSED BY THE STUDY & DATA PRESENTED. I DO NOT THINK THAT THE GENERAL PUBLIC WILL UNDERSTAND THE IMPLICATIONS. -- THEY WILL KEY IN ON THE PERCENTAGE.

Robert Jay
Administrator

COTTONWOOD HOSPITAL MEDICAL CENTER

October 23, 1987

Dr. William Roper, MD Administrator
Department of Health & Human Services
HCFA
6325 Security Blvd.
Baltimore, MD 21207

Dear Dr. Roper;

Cottonwood Hospital Medical Center is pleased to participate in the HCFA Mortality Study. We are dedicated to providing the highest quality health care to the community we serve. We also appreciate the opportunity to comment on the data which has been collected and hope this input will benefit your efforts. Our Medicare provider number is 460006.

DATA VERIFICATION

The data used by HCFA indicate that a total of 1,448 Medicare patients were admitted to Cottonwood Hospital in 1986 and that 168 died within 30 days of admission. Of these, 110 patients died while still at the hospital and 58 died after discharge. Our own records indicate that 2,214 Medicare admissions occurred in 1986. We have not confirmed the number of patients who died outside the hospital after discharge. The 110 listed by Medicare as having died in the hospital is correct. The 2,214 admissions account for multiple hospitalizations for the same patient where as the 1,448 admissions are the patient's last admission prior to their death.

INTERPRETIVE COMMENTS AND PRELIMINARY MEDICARE RECORD REVIEW

In the diagnostic category of Severe Chronic Heart Disease, the hospital's reported mortality rate falls outside the range of the predicted mortality rate. After preliminary review of the HCFA data and Cottonwood Hospital patient records, we would like to clarify a number of areas.

1. There were 12 patients who died in the hospital and 6 patients who died outside the hospital within 30 days of admission.

2. Of the 18 deaths listed in this category, 13 patients had 4 or more co-morbid conditions.

3. Following a preliminary review of the charts, 6 of the patients suffered from cardiomyopathy as an underlying cause of congestive heart failure. The mortality rate for cardiomyopathy is higher than the norm.

4. There were two patients who had severe COPD (Chronic Obstructive Pulmonary Disease) as an underlying cause of CHF.

5. Of the 6 patients who died outside the hospital, 5 were discharged either to a nursing home or home for terminal care. One was discharged with 6 co-morbid conditions.

6. Of the 12 patients who died in the hospital, 10 deaths were expected upon admission to the hospital.

7. The average age of patients seen in this category was 79 years of age.

8. The sample size is fairly small in this area with only 43 patients being treated and 18 deaths occurring. We are concerned that this does not objectively reflect the care provided at Cottonwood Hospital.

If you need additional information on these comments, please contact Karen Hardwick at (801) 269-2908. We appreciate the opportunity to view this information.

Sincerely,

Floyd J. McDermott
Administrator

Thomas L. Jones, MD
President Medical Staff

/pky

DIXIE MEDICAL CENTER
544 South 400 East • St. George, Utah 84770 • 634-4000
L. Steven Wilson, Administrator

COMMENTS ON THE HCFA MORTALITY DATA

Dixie Medical Center, St. George, Utah
MEDICARE PROVIDER NO: 460021

Interpretive Remarks

In all of the diagnostic categories, the hospital's mortality rate falls inside the range of predicted mortality rate. Nevertheless, we would like to offer explanation of our mortality rate in the pulmonary disease category.

We offer a pulmonary service unique to our area. That service includes a full-time pulmonologist who is board certified in Internal Medicine. Our climate entices people with severe pulmonary disease to locate in our service area.

Ten of the 13 hospital deaths were the result of following patients' and families' wishes with respect to extraordinary life support in the face of severe chronic pulmonary disease. None of the five deaths that occurred within 30 days of discharge from the hospital were unexpected.

L. Steven Wilson
Administrator

October 28, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to review the mortality information on Medicare patients for 1986 which you will be publishing. We do appreciate the opportunity to review the accuracy of this information.

Enclosed with this letter is a brief statement concerning the one area in which we had a slight variation with the range of predicted mortality rates. After consultation with physicians, it is our impression that this is an expectable outcome.

We regret the lateness with which this response has reached you. It is important for you to realize that the original mailing did not reach this hospital. We have carefully researched possible delivery and cannot find any indication that we ever received the initial mailing of information from you. For this reason, our response has been delayed. Thank you for your consideration of our comments.

Sincerely,

Kenneth H Rock

Kenneth H. Rock
President

KHR/kk
Enclosure

HOLY CROSS HOSPITAL
1045 EAST FIRST SOUTH
SALT LAKE CITY, UTAH 84102
(801) 350-4111

A MEMBER OF HOLY CROSS HEALTH SYSTEM SOUTH BEND, INDIANA



In response to the mortality information furnished to this hospital, we wish to make the following comments:

1. All cases sighted by the Health Care Financing Administration report were reviewed. The severity of illness and the extent of neurologic damage of each of these patients at the time of admission was adequate explanation for the outcome.

HOLY CROSS HOSPITAL
1045 EAST FIRST SOUTH
SALT LAKE CITY, UTAH 84102
(801) 350-4111

A MEMBER OF HOLY CROSS HEALTH SYSTEM, SOUTH BEND, INDIANA

Humana Hospital
Davis North

OCTOBER 26, 1987

Dr. Roper, Administrator
Department of Health and Human Services
Healthcare Finance Administration
6325 Security Boulevard
Baltimore, Maryland 21207

Dear Dr. Roper:

I have received your information on Morbidity and Mortality Data for Humana Hospital-Davis North and appreciate the opportunity to comment on that data. I appreciate that the program is in the early stages of its development and while its measurements are preliminary and extremely rough it is clearly an example of the type of quality measurements to come.

The data may be useful in this format for professional evaluation but it is surely not understandable by consumers nor beneficial for their use. Also I would hope that consumers would be informed as to the limited scope of these numbers and cautioned about drawing any conclusion from the data.

In our hospital we have a complete internal review of all deaths as a part of our ongoing Quality Assurance program. It is useful to our physicians and to the rest of the staff to identify patient trends and treatment outcomes. I would hope that the audiences that receive this data fully understand the extensive quality control systems in place in our hospital and other hospitals in general.

The data you provided has been reviewed by a hospital Quality Assurance Program and the Medical Staff. Even though some of the deaths occurred outside the hospital we have been able to validate all of the post hospital deaths but one.

On those that died within 30 days of leaving the hospital our medical records indicate that their death was expected and in general they were sent home with their families to die surrounded by their loved ones. In only one case were we able to validate and correlate his hospital stay with his death.

Unfortunately, in most cases, the number of patients in a particular category is too small to provide any valid statistical analysis. Also I was surprised in the predicted ranges and the broadness and because of that broadness and the low number of cases the data provided is meaningless.

I hope in the future that your statistical methodology and your data will be more refined and will not just report raw hospital data. However, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve healthcare services.

Sincerely,

Dean S. Holman
Executive Director

DSH:sr

HCA Pioneer Valley Hospital

Medicare Provider No.: 460008

October 22, 1987

Department of Health & Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

Dear Sirs:

We appreciate the opportunity of reviewing the mortality information regarding Medicare patients treated during 1986. This information was utilized to perform a study of these patients with regard to their care at Pioneer Valley Hospital. We have focused on the areas with the three highest mortality rates, including cerebrovascular accidents, severe acute heart disease and pulmonary disease. It should be noted that in no instance, did mortality rates for Pioneer Valley Hospital meet or exceed the standards listed.

These categories included thirty-eight patients who expired within 30 days following discharge. Of these patients, 92 percent (32) were admitted in very poor condition and with dismal prognoses. An additional 50 percent (19) of these patients were admitted with NCR (no cardiac resuscitation) orders. Of the 38 patients reviewed, 37 had severe chronic systemic diseases complicating their current acute disease process. The average age of these patients was 73.5 years.

Data was collected for each case, and no trends or adverse effects of treatment were noted. The deaths were distributed evenly among treating physicians, thus identifying no pattern of inferior care.

Again, we appreciate the opportunity to study this mortality data in the hopes of identifying any possible problems in patient care that may be present.

Sincerely,

Kay Matsumura
Administrator

KM:sg

3460 South Pioneer Parkway
West Valley City, Utah 84120
Telephone (801) 964-3100
A Subsidiary of HCA The Healthcare Company

St. Benedict's HOSPITAL
A MEMBER OF HOLY CROSS HEALTH SYSTEM

TO: Health Care Financing Adminstration
Health Standards & Quality Bureau
Hospital Mortality Information

FROM: St. Benedict's Hospital Provider #460005
5475 South 500 East
Ogden, UT 84405

DATE: October 23, 1987

SUBJECT: Errors found in HCFA Mortality Data

Pt. ID	Surname	Date of Admit	Date of DC
[redacted]	[redacted]	10/15/86	10/24/86
[redacted]	[redacted]	04/13/86	04/14/86

We have no record of the above two patients for those dates of hospitalization.

[redacted] [redacted] 11/10/86 11/11/86
Date of discharge should be 11/10/86, same day as date of death.

[redacted] [redacted] 01/22/86 02/01/86
Incorrect principal diagnosis, 2800 listed. Correct principal diagnosis was 556.

[redacted] [redacted] 09/26/86 10/06/86
Patient was readmitted on 10/24/86 with a principal diagnosis of 78559. Patient expired same day, 10/24/86, at St. Benedict's Hospital.

If any questions, please call Pat Henthorne, R.N., (801)479-2468.

so

University Hospital

THE UNIVERSITY OF UTAH

October 19, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To Whom It May Concern:

Thank you for the opportunity to review and respond to the 1986 mortality report for University of Utah Hospital.

Our management team, including hospital administrators, the leadership of the medical staff and representatives from nursing, medical records and quality assurance, has reviewed the data and found them to be essentially correct.

While we note that University of Utah Hospital was at or below the predicted mortality ranges in five of the 16 diagnostic categories analyzed and well within the predicted ranges in the remaining 11 categories, we recommend caution in interpreting these data and attempting to use them in isolation to make health-care decisions. We concur with the HCFA administrator's own qualifying statement, that, "While we believe...information on hospital mortality rates is useful, until we have developed additional statistical measures to deal with complex issues such as severity of illness, we cannot and do not recommend the use of the information by itself to make judgments...."

Recent developments in computer technology and quality of care evaluation are enabling these interpretive studies to be made. They are yet another example of our entry into the "Information Age." They hold promise of helping consumers make better health care decisions, but, as of now, they must be considered tentative, perhaps even primitive, and caution must be used in interpreting them and using them to make decisions.

George W. Belsey
Administrator

M. Peter Heilbrun, M.D.
President of the Medical Staff

University of Utah Hospital's Medicare number is 460009

Office of the Administrator
Room 1100
50 North Medical Drive
Salt Lake City, Utah 84132
(801) 581-2378

VALLEY VIEW MEDICAL CENTER

595 South 75 East, Cedar City, Utah 84720 / 801-586-6587

COMMENTS ON HCFA MORTALITY DATA

Data Verification:

The data used by HCFA indicate that a total of 25 Medicare patients admitted to Valley View Medical Center died within 30 days of admission. Of these, 13 died while still a patient of the hospital, while 12 (48.0%) died after discharge. Our records indicate that 334 Medicare admissions occurred in 1986, while HCFA records indicate 224 admissions. Presumably the discrepancy reflects multiple admissions of individual beneficiaries. All deaths listed during hospitalization have been verified by hospital records; however, it is impossible to determine the percentage of the 12 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis. However, the diagnostic category to which a patient is assigned apparently relates to the principal diagnosis at the time of admission to the hospital, rather than to the cause of death, as at least 2 patients, known to us, expired post discharge due to causes completely unrelated to the reason for hospital admission. These patients are as follows:

[redacted] -- hospitalized initially because of back pain. Massive liver enlargement noted during hospitalization, and patient expired at another facility due to CA of liver. Patient classified in the orthopedic category -- should be CA.

[redacted] hospitalized because of acute glaucoma. Expired post discharge of causes relating to his chronic diseases, unrelated to ophthalmological problems.

Interpretive Remarks:

While review of HCFA statistics and the medical records reveals that Valley View Medical Center's actual mortality rate falls within the range of predicted mortality rate in all categories, we feel that some changes in the evaluation process would provide more meaningful data.

1. It would seem that categorizing patients to the cause of death, rather than to the principal diagnosis for the most recent hospital admission would provide a much more valid statistic. Information relating to the cause of death should be available to you with the death statistics.

2. Several of the ranges of predicted mortality rates for specific diagnostic categories for our hospital are 0 to 100%, and the importance of a percentage of deaths which falls within this range would appear to be questionable. These categories are the low-risk categories, however, and based upon our experience, the actual cause of death in most situations would be related to other causes, i.e. cardiovascular, carcinoma, etc.

3. Based upon the statistical information available to us, it would appear that many deaths are being counted against multiple facilities, i.e. patients who are admitted to one institution, transferred to another for more definitive treatment, and then perhaps to a hospice, thus giving the impression of a significantly higher death rate than actually exists. This is the case with at least two of the people shown as having expired within 30 days after discharge from this hospital. In both instances, the patients were transferred to other health care facilities or where subsequently hospitalized at other facilities where they died while patients at those facilities.

While tabulation of mortality statistics can provide useful information, publication of data which does not really relate to the cause of death, which does not account for extenuating factors, or which gives the impression of a higher death rate than actually exists will only cause unnecessary concern and confusion for the public.

Mark F. Dalley, Administrator

HOSPITAL = 460036 WASATCH COUNTY HOSPITAL HEBER CITY UT

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	171	18 %	8 TO 20 %
CA - CANCER	4	50 %	1 TO 74 %
CE - CEREBROVASCULAR ACCIDENTS	7	57 %	9 TO 70 %
GC - GASTROINTESTINAL CATASTROPHES	5	0 %	1 TO 68 %
GI - GASTROINTESTINAL DISEASE	21	5 %	0 TO 28 %
GU - UROLOGIC DISEASE	4	0 %	0 TO 76 %
GY - GYNECOLOGIC DISEASE	2	0 %	0 TO 100 %
HL - LOW-RISK HEART DISEASE	18	0 %	0 TO 31 %
HM - SEVERE CHRONIC HEART DISEASE	9	11 %	6 TO 59 %
HS - SEVERE ACUTE HEART DISEASE	9	33 %	12 TO 68 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	6	83 %	7 TO 72 %
OP - ORTHOPEDIC DISORDERS	4	25 %	0 TO 100 %
PN - PULMONARY DISEASE	30	27 %	9 TO 38 %
RN - RENAL DISEASE	2	0 %	0 TO 91 %
SE - SEPSIS	1	0 %	1 TO 98 %
TR - SEVERE TRAUMA	1	0 %	0 TO 97 %

The enclosed information is accurate according to our records.

Wayne D. Perry
administrator

UT 43

Vermont

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BRATTLEBORO MEMORIAL HOSPI BRATTLEBORO VT 05301	VT-3 *	622	13	9-17	42	31	15-43	21	19	13-51	13	31	3-46	33	24	14-44	28	32	21-56	9	0	2-54	74	27	13-34
CENTRAL VERMONT HOSPITAL BARRE VT 05641	VT-4 *	1557	12	9-16	114	30	15-34	75	17	19-41	34	15	7-35	89	21	15-34	55	40	27-54	38	13	6-34	135	16	12-27
COPLEY HOSP MORRISVILLE VT 05661	VT-5	450	10	9-17	29	24	9-41	14	21	9-54	9	0	3-54	26	12	10-42	24	33	22-60	9	11	1-52	69	14	10-30
FANNY ALLEN HOSP WINOOSKI VT 05404	VT-6 *	1000	11	9-17	72	33	17-40	43	19	17-45	19	26	5-41	59	24	12-34	33	18	22-55	33	9	10-40	117	15	13-30
GIFFORD MEMORIAL HOSP INC RANDOLPH VT 05060	VT-7 &	377	13	11-21	29	31	12-45	29	34	17-50	12	25	3-48	25	16	10-42	18	28	16-58	10	10	7-58	60	8	11-33
GRACE COTTAGE HOSP TOWNSHEND VT 05353	VT-8 *	97	23	11-28	7	71	14-78	5	60	3-71	1	0	0-99	9	11	6-59	7	29	13-76	3	0	0-84	16	31	9-50
MEDICAL CENTER HOSPITAL OF BURLINGTON VT 05401	VT-9	2815	12	8-14	286	26	18-33	62	35	17-40	46	15	7-31	94	27	15-33	101	42	27-47	24	13	4-37	134	27	13-29
MT ASCUTNEY HOSPITAL HEAL WINDSOR VT 05089	VT-10 *	294	14	9-19	20	40	8-45	20	20	15-55	4	75	5-79	24	29	10-44	15	40	20-66	5	20	2-70	30	17	9-39
NORTH COUNTRY HOSP&HEALTH NEWPORT VT 05855	VT-11 *	651	13	11-19	35	40	15-46	23	22	14-50	17	6	7-47	29	10	11-43	34	44	23-56	14	7	4-46	85	16	16-36
NORTH EASTERN VERMONT REG SAINT JOHNSBURY VT 05819	VT-12 *	555	11	9-17	28	21	16-51	24	17	13-49	24	25	5-36	40	18	11-37	29	17	22-57	6	0	1-63	46	20	12-37
NORTHWESTERN MEDICAL CENTE SAINT ALBANS VT 05478	VT-13 *	710	14	9-17	38	47	18-49	25	20	13-47	20	10	5-41	48	15	13-37	38	39	21-51	20	10	5-41	60	7	8-29
PORTER MEDICAL CENTER INC MIDDLEBURY VT 05753	VT-14 *	412	11	8-17	20	20	8-45	17	35	12-53	10	20	7-59	26	27	11-43	18	39	20-64	6	17	1-63	54	19	11-34
ROCKINGHAM MEM HOSP BELLOWS FALLS VT 05101	VT-15 *	251	15	9-19	23	57	15-53	9	33	12-69	3	33	0-85	19	37	10-48	8	0	13-72	4	25	1-74	26	19	7-38 8
RUTLAND REGIONAL MEDICAL C RUTLAND VT 05701	VT-16	2151	12	9-15	160	35	20-38	84	18	18-38	40	18	6-31	135	24	17-32	83	48	28-50	67	10	7-29	162	17	12-27
SOUTHWESTERN VT MEDICAL CT BENNINGTON VT 05201	VT-17	1390	8	9-15	85	16	18-40	57	14	17-41	28	21	7-38	67	18	13-34	52	29	25-52	22	5	4-37	113	21	12-29
SPRINGFIELD HOSPITAL INC SPRINGFIELD VT 05156	VT-18 *	673	10	8-16	35	11	10-40	28	29	16-50	13	8	6-51	36	19	13-41	35	34	23-55	4	0	0-75	77	19	11-30

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
BRATTLEBORO MEMORIAL HOSPI BRATTLEBORO VT 05301	6	33	4-69	4	25	3-77	29	10	3-28	5	0	0-100	85	5	2-13	22	5	0-28	8	0	0-100	37	8	1-19	56	0	0-12
CENTRAL VERMONT HOSPITAL BARRE VT 05641	15	47	9-56	13	31	17-67	43	9	2-21	14	0	0-97	151	5	2-10	100	4	1-12	8	0	0-100	107	6	2-11	91	5	0-8
COPLEY HOSP MORRISVILLE VT 05661	3	0	1-82	3	67	6-87	15	13	2-38	.	.		50	2	2-17	17	0	0-36	2	0	0-100	45	2	2-17	26	4	0-35
FANNY ALLEN HOSP WINOOSKI VT 05404	6	50	5-70	9	22	10-67	31	16	3-26	18	0	0-58	113	6	2-11	43	0	0-19	9	0	0-99	81	4	2-13	37	0	0-18
GIFFORD MEMORIAL HOSP INC RANDOLPH VT 05060	7	71	7-70	7	14	8-70	11	0	1-44	1	0	0-100	31	0	1-21	4	25	0-94	2	0	0-100	22	9	1-27	21	0	0-42
GRACE COTTAGE HOSP TOWNSHEND VT 05353	1	100	3-99	.	.		3	0	0-84	.	.		5	0	0-53	2	0	0-92	.	.		5	20	1-67	2	0	0-100
MEDICAL CENTER HOSPITAL OF BURLINGTON VT 05401	35	14	9-44	23	35	21-62	52	6	2-19	57	0	0-25	177	9	3-10	77	0	1-14	23	0	0-73	535	6	4-8	180	3	0-5
MT ASCUTNEY HOSPITAL HEAL WINDSOR VT 05089	3	33	1-83	2	0	2-90	9	11	1-50	2	0	0-100	24	0	1-25	17	0	0-34	.	.		12	0	0-44	16	0	0-51
NORTH COUNTRY HOSP&HEALTH NEWPORT VT 05855	17	12	3-53	13	31	11-60	11	18	2-46	3	0	0-100	71	8	2-15	14	0	1-38	2	0	0-100	59	8	1-14	30	0	0-25
NORTH EASTERN VERMONT REG SAINT JOHNSBURY VT 05819	3	33	3-85	4	25	3-77	28	7	3-29	3	0	0-100	54	9	2-17	11	27	0-45	4	0	0-100	45	2	1-17	42	0	0-16
NORTHWESTERN MEDICAL CENTE SAINT ALBANS VT 05478	5	20	8-79	15	38	15-61	19	11	2-32	.	.		93	4	2-13	24	8	1-27	8	0	0-89	87	9	2-12	27	4	0-28
PORTER MEDICAL CENTER INC MIDDLESBURY VT 05753	1	0	1-97	1	0	1-97	9	0	0-54	9	0	0-100	55	4	1-15	18	17	1-32	3	0	0-100	35	3	1-19	25	0	0-30
ROCKINGHAM MEM HOSP BELLOWS FALLS VT 05101	1	0	0-100	.	.		4	0	0-60				32	3	1-22	3	0	0-87	1	0	0-100	21	0	1-27	12	0	0-68
RUTLAND REGIONAL MEDICAL C RUTLAND VT 05701	14	43	9-57	16	38	14-59	68	4	3-18	20	0	0-88	210	4	2-9	68	3	2-16	25	0	0-77	188	7	3-9	179	2	0-6
SOUTHWESTERN VT MEDICAL CT BENNINGTON VT 05201	7	0	5-67	16	19	15-60	39	3	3-24	21	0	0-69	150	2	3-11	52	0	1-17	15	7	0-90	79	1	2-12	120	2	1-7
SPRINGFIELD HOSPITAL INC SPRINGFIELD VT 05156	4	25	1-76	8	38	10-70	22	5	3-33				91	8	2-12	18	6	0-36	3	0	0-100	58	0	1-14	51	0	0-14

*Written Comments Not Submitted.

MCHV
Medical Center Hospital of Vermont

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Sir or Madam:

RE: Medical Center Hospital of Vermont comments regarding our hospital-specific mortality rates received from the Health Care Financing Administration in early October 1987

The Medical Center Hospital of Vermont (MCHV) recognizes the importance and complexity of providing consumers with useful and reliable information on the quality of care available to them, and supports the Health Care Financing Administration's efforts to assist in this cause. MCVH is strongly committed to providing high quality patient care and maintains a comprehensive and integrated institutional quality assurance program. The primary goal of institutional quality assurance efforts are to prevent problems from arising. The Quality Assurance Department, in collaboration with the medical staff, have objectively and comprehensively reviewed our institution specific mortality data. We submit the following comments for your consideration so that the methodology can be further improved and its utility to hospital quality assurance programs enhanced.

Information provided to Hospitals

Hospitals cannot validate the HCFA mortality rates because we are not able to identify the total population in the report, only the mortalities.

Additionally, hospitals cannot scientifically analyze the data because we have not been provided a detailed description of the HCFA methodology for establishing predicted mortality ranges. This is necessary to further analyze sub-groups of the Medicare patients and to expand the population to include non-Medicare patients.

(802) 656-2345
Burlington, Vermont 05401
A Vermont Health Foundation Company

Impact of Secondary Diagnoses

The diagnostic categories do not always accurately classify the nature of the patient's illness since they consider only the principal diagnosis. For example, MCHV experienced 5 deaths in the orthopedic conditions category. Three of these were cancer patients with pathological fractures and the other two had unrelated terminal co-morbidities.

Medicare Data Base Inconsistencies

MCHV was identified as a high-side outlier for acute myocardial infarctions when HCFA released mortality data for the 1984 Medicare population in DRGs 121 - 123. After a comprehensive and unsuccessful internal review of possible contributing factors, MCHV worked with the Vermont State Health Department to identify external variables which may explain our apparent high mortality rate. We observed major differences in the percent of patients with cardiovascular diagnoses of AMI (ICD-9-410) and those with diagnoses of unstable angina (ICD-9-411). AMI accounted for 13.8% of CV diagnoses and unstable angina accounted for 27.2% of CV diagnoses at MCHV. At other Vermont hospitals AMI accounted for 20.6% of CV diagnoses and unstable angina 13.1% of CV diagnoses. On a proportionate basis, the ratio of AMI patients to unstable angina patients was 0.52 at MCHV at 1.57 at other Vermont hospitals. These data suggested that the diagnosis of AMI and subsequent coding of AMI patients at MCHV differed substantially from that at other Vermont hospitals. This example represents the variation in diagnoses, documentation, and subsequent coding among hospitals which could significantly influence the reliability of the basic Medicare data.

Severity of Illness

MCHV is a 500 bed acute care referral center providing advanced diagnostic procedures and specialized care for patients with severe and complex illnesses. We recognize that HCFA included a few patient characteristics in this statistical model, but the data available to Medicare do not include the clinical characteristics necessary to accurately adjust for patient severity in a referral center population. For example, it is interesting to note that approximately 50% of all 1986 Medicare mortalities at MCHV were admitted through the Emergency Room. Approximately 20% of the total patient population at MCHV is admitted through the Emergency Room. In two diagnostic categories that MCHV fell on the high side of the range, more than 70% of the patients were admitted in this manner. This data and the results of internal chart review suggest that the mortalities occurred in an extremely ill population. A more sophisticated severity indexing methodology is necessary to address this concern.

In conclusion, MCHV commends HCFA for their commitment to disseminate information to hospitals to assist in problem identification and to provide consumers with meaningful information on the quality of care available to them. However, mortality statistics represent only one component of a comprehensive methodology to evaluate hospital quality. Hopefully, HCFA, JCAHO, and other organizations who are presently investigating methods of evaluation will collaborate and develop a comprehensive approach which is valuable both to hospitals and consumers. Most importantly, however, individual patient treatment decisions at MCHV are decided through informed discussion between the patient and physician. Mortality and morbidity risks are discussed, and ethical issues, realistic medical options, and the overall risk - benefit ratio for each individual patient are thoughtfully considered. Until methodologies for the evaluation of the quality of patient care are validated and integrated in the decision making process, caution should be exercised to avoid the disruption of positive patient- physician relations.

Respectfully,

Dean E. Lea

Dean E. Lea
Vice President for Quality Assurance

/map

Rutland Regional Medical Center
160 Allen Street
Rutland, Vermont 05701
(802) 775-7111

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

I am writing on behalf of Rutland Regional Medical Center (Medicare Provider Number 470005), a not-for-profit, 206 bed hospital in rural Vermont. Rutland Regional Medical Center is a designated Sole Community Provider and a Rural Referral Center as designated by your agency. It is one of only 19 hospitals nationally with this dual desigantion. RRMC is the second largest hospital in Vermont, in the second largest community. The hospital provides care to all individuals without regard to ability to pay.

We have reviewed the mortality data provided to us in September of 1987. We are pleased to note that, in every case, the actual mortality rate at RRMC did not exceed the predicted ranges. The hospital specific mortality rates, as determined by the HCFA methodology, offer a new perspective in the review of the hospitals. The acceptance of this methodology will be much higher once its relative value is determined and once some recognition of the comparative severity or complexity of illness of patient populations is recognized. Although these rates are highly questionable when viewed alone as a measure of care quality, they do appear to have potential as a screening or surveillance tool. When followed over time so the consistency of any given pattern can be established and so the problem of small numbers in any given year can be overcome, these mortality rates can be combined with other screening tools, such as small area variation analysis, medisgroups, mortality conferences, and case reviews to identify areas of practice strength or weakness.

Taken alone, the hospital specific mortality rates are likely to be misleading, but when combined with methodologies of proven worth, there may be a positive contribution.

William L. Roper, M.D.
October 27, 1987

I am pleased to report that, to the best of our knowledge, RRMC is the first hospital in the country to utilize both small area variation analysis techniques with a "severity of illness" measurement technique (Medisgroups) on a continuing basis, to monitor appropriateness and quality of care provided to our community.

In conclusion, Rutland Regional Medical Center is committed to providing high quality care to the people we serve; therefore, we are committed to investigating any potential quality problem so that corrective action may be taken. The mortality data which you have provided will be reviewed by our Peer and Utilization Review Committee in order to determine if further analysis is required.

Sincerely,

Richard T. Schmidt

Richard T. Schmidt
President

RTS:jre

James E. Cassidy, F.A.C.H.E.
President

SOUTHWESTERN VERMONT MEDICAL CENTER

100 Hospital Drive East, Bennington, VT. 05201
(802) 442-6361

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

In reviewing the data submitted by HCFA regarding Medicare mortalities in 1986 for this hospital, we have found a number of discrepancies. Specifically, we have identified eleven (11) instances where we have discrepancies relating to the patient's age. Additionally, there are nine (9) instances where our records indicate differing principal procedure codes. There is one instance of differing principal diagnosis codes and one difference in date of discharge.

In reviewing the mortality data released by HCFA, it is our belief that there are a number of pertinent variables relating to expected mortality rates that were not accounted for in your model. Among the factors we feel HCFA's model fails to consider are severity of patient illness, the stage of the patient's illness, the patient's psychological condition, and the amount of family support.

Lastly, and most significantly, we strongly believe that mortality is not directly related to quality of care. As a 160-bed non-profit hospital, we and our medical staff, spend a great amount of effort and resources on our quality assurance program. The ongoing review of all mortalities at this institution is but a small component of what we feel are significant indicators of quality care.

Sincerely,

James E. Cassidy
President

JEC/prm

Virgin Islands

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST CROIX HOSP AND COMM HEA CHRISTIANSTED VI 00820	VI-3 *	303	15	8-17	13	31	8-55	21	38	12-50	9	33	4-56	32	19	11-40	8	50	12-71	8	38	4-60	22	32	8-43
ST THOMAS HOSP AND COMM HE SAINT THOMAS VI 00801	VI-4 *	146	10	5-16	9	56	3-54	6	33	6-69	3	0	0-85	12	0	5-50	4	50	9-85	7	14	3-61	12	17	2-45

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST CROIX HOSP AND COMM HEA CHRISTIANSTED VI 00820	6	0	3-67	1	100	1-97	2	0	0-99	6	0	0-100	32	6	1-20	10	0	0-74	3	0	0-100	38	16	1-19	11	0	0-67
ST THOMAS HOSP AND COMM HE SAINT THOMAS VI 00801	.	.		1	100	2-98	1	0	0-100	6	0	0-100	12	0	0-52	8	0	0-59	.	.		4	0	0-87	8	13	0-85

*Written Comments Not Submitted.

Virginia

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALEXANDRIA HOSPITAL ALEXANDRIA VA 22304	VA-11	1858	10	8-14	153	27	15-32	48	25	15-41	42	17	9-35	103	22	15-32	69	25	25-49	44	9	9-36	140	15	11-25
ALLEGHENY HOSPITAL CLIFTON FORGE VA 24422	VA-12 *	1672	10	9-15	75	31	19-43	52	15	17-42	27	22	8-39	82	32	15-34	55	25	28-55	48	0	7-32	156	21	13-28
ARLINGTON HOSP ARLINGTON VA 22205	VA-13	2128	11	9-16	162	26	18-35	88	33	17-37	37	19	10-38	102	20	14-31	79	33	30-53	57	37	14-40	143	19	13-28
BATH COUNTY COMMUNITY HOSP HOT SPRINGS VA 24445	VA-14 *	185	10	10-22	6	67	6-70	6	33	5-69	7	0	5-64	15	7	7-47	10	10	15-69	8	38	5-61	39	8	9-34
BEOFORO COUNTY MEMORIAL HO BEOFORO VA 24523	VA-15 *	492	16	10-18	21	29	9-46	26	35	14-48	10	20	3-52	49	24	11-35	30	20	22-57	13	31	8-55	39	31	11-38
BLUE RIDGE HOSPITAL OIV CHARLOTTESVILLE VA 22901	VA-16 *	8	0	0-55	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
BLUE RIDGE HOSPITAL OIVISI CHARLOTTESVILLE VA 22901	VA-17 *	150	12	5-16	11	82	11-63	2	0	3-91	.	.		1	0	1-97	1	0	0-97	2	0	0-90	3	33	2-81
BUCHANAN GENERAL HOSP GRUNDY VA 24614	VA-18 *	1139	6	7-14	24	58	20-58	21	24	13-51	8	0	1-55	42	17	10-35	36	42	22-53	44	11	10-37	221	6	9-22
CENTRAL VIRGINIA TRAINING LYNCHBURG VA 24504	VA-19 *	150	3	2-12	1	0	0-99	.	.		7	0	1-59	1	0	0-97	1	0	0-97	3	0	0-92	22	14	4-34
CHESAPEAKE GEN HOSP CHESAPEAKE VA 23320	VA-20	1668	15	9-15	102	26	15-34	55	35	17-41	28	32	6-36	92	26	14-31	58	47	25-51	33	21	6-35	166	31	13-27
CHIPPENHAM HOSP RICHMOND VA 23225	VA-21	2785	10	7-14	139	22	15-33	94	32	19-39	40	18	9-35	131	23	15-30	104	33	27-48	80	18	9-30	197	14	11-24
COMM HOSP OF ROANOKE VALLE ROANOKE VA 24029	VA-22	2503	11	9-15	225	24	16-32	79	24	21-42	42	5	6-30	111	23	16-33	86	38	28-50	57	23	12-38	223	21	14-27
COMMUNITY MEMORIAL HOSP SOUTH HILLS VA 23970	VA-23 *	963	14	9-16	39	44	15-45	66	23	17-40	18	11	4-40	62	27	12-32	50	36	24-52	30	13	7-38	92	20	11-29
CULPEPER MEM HOSP INC CULPEPER VA 22701	VA-24 *	701	12	8-16	40	38	11-39	17	24	11-52	16	19	3-40	33	21	11-39	32	25	23-56	18	28	3-40	82	23	12-30
OEPAUL HOSP NORFOLK VA 23505	VA-25	2518	11	8-14	242	19	16-31	101	25	18-37	59	20	7-29	115	17	13-29	85	46	26-48	58	17	9-33	180	18	11-25
OICKERSON COUNTY MEO CNTR CLINTWOOO VA 24228	VA-26 *	43	0	3-24	.			.	.		.	.		3	0	1-81	.	.		.	.		8	0	2-56
EASTERN STATE HOSP WILLIAMSBURG VA 23185	VA-27	129	12	6-19	.	.		5	80	6-75	3	0	0-85	4	25	3-76	1	100	2-98	14	14	3-44	35	14	7-33
FAIR OAKS HOSP FAIRFAX VA 22033	VA-28	864	13	8-15	35	20	13-44	41	17	14-42	19	16	4-38	39	23	11-37	40	55	28-59	17	29	10-52	84	21	9-27
FAIRFAX HOSP FALLS CHURCH VA 22046	VA-29	3435	10	8-14	296	22	16-31	128	27	20-37	75	13	8-28	138	21	16-31	102	40	29-49	72	13	9-32	188	24	14-28
FRANKLIN MEMORIAL HOSP ROCKY MOUNT VA 24151	VA-30	485	13	9-18	13	15	7-52	19	42	13-53	16	6	6-47	28	21	10-41	23	26	19-58	19	11	6-44	81	10	9-28 8
GILES MEMORIAL HOSPITAL PEARISBURG VA 24134	VA-31 *	414	14	8-17	18	39	12-53	17	29	12-54	8	50	2-55	34	24	13-42	14	43	17-64	10	30	4-53	52	12	9-32
GILL MEMORIAL EYE EAR NOSE ROANOKE VA 24011	VA-32	110	1	0-15	2	0	1-89	.	.		.	.		.	.		.	.		.	.		.	.	
GREENSVILLE MEM HOSPITAL EMPORIA VA 23847	VA-33 *	887	14	10-17	32	50	14-46	54	30	17-42	23	13	4-35	68	16	14-34	39	28	21-51	35	14	8-37	123	19	12-27
GRUNDY HOSP GRUNDY VA 24614	VA-34 *	5	0	0-75	.			.	.		.	.			.		.	.		.	.		2	0	0-93
HALIFAX COMMUNITY HOSP SOUTH BOSTON VA 24592	VA-35	1368	12	9-16	88	34	15-36	52	37	16-41	33	12	6-34	114	16	13-29	39	38	23-54	67	19	8-30	135	19	13-29
HAMPTON GENERAL HOSP HAMPTON VA 23669	VA-36	2011	13	9-15	149	30	16-33	98	32	18-37	39	15	7-33	109	20	15-32	67	31	25-49	90	13	10-31	162	22	13-27

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ALEXANDRIA HOSPITAL ALEXANDRIA VA 22304	17	24	5-48	13	54	11-60	51	8	2-20	5	0	0-100	166	5	2-10	62	3	1-15	24	0	0-80	150	4	2-9	128	2	0-7 8
ALLEGHENY HOSPITAL CLIFTON FORGE VA 24422	25	28	12-52	11	36	13-66	32	6	3-27	10	0	0-98	169	5	4-12	67	1	2-16	11	0	0-56	156	5	3-11	99	0	0-8
ARLINGTON HOSP ARLINGTON VA 22205	8	25	6-65	23	43	20-60	66	5	3-18	13	0	0-87	246	4	3-9	78	3	2-15	19	0	0-92	155	5	2-9	145	0	0-6
BATH COUNTY COMMUNITY HOSP HOT SPRINGS VA 24445	1	0	0-98	5	20	11-81	.	.		.	.		14	0	1-37	1	0	0-100	.	.		22	9	0-26	4	0	0-100
BEDFORD COUNTY MEMORIAL HO BEDFORD VA 24523	6	33	5-70	7	43	5-66	21	19	2-31	2	0	0-100	45	2	2-18	16	6	0-38	5	0	0-100	25	0	0-24	17	0	0-52
BLUE RIDGE HOSPITAL DIV CHARLOTTESVILLE VA 22901	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
BLUE RIDGE HOSPITAL DIVISI CHARLOTTESVILLE VA 22901	.	.		.	.		.	.		.	.		3	33	0-85	.	.		.	.		1	100	0-98	1	0	0-100
BUCHANAN GENERAL HOSP GRUNDY VA 24614	9	11	7-65	2	0	4-92	6	33	0-64	.	.		133	3	2-11	46	0	1-18	3	0	0-100	194	1	2-8	38	0	0-25 8
CENTRAL VIRGINIA TRAINING LYNCHBURG VA 24504	1	100	0-98	2	0	3-91	3	0	0-92	5	0	0-100	9	0	0-62	10	0	0-55	4	0	0-100	6	0	0-80	9	0	0-66
CHESAPEAKE GEN HOSP CHESAPEAKE VA 23320	18	17	6-49	50	40	24-53	39	13	2-22	7	0	0-99	160	6	2-10	66	6	2-16	12	0	0-100	129	4	2-10	122	1	0-7
CHIPPENHAM HOSP RICHMOND VA 23225	31	29	10-47	25	20	19-57	61	8	3-18	4	0	0-100	198	5	2-9	124	5	2-12	20	0	0-99	378	3	3-8	166	1	0-6
COMM HOSP OF ROANOKE VALLE ROANOKE VA 24029	24	25	10-50	8	50	13-73	66	3	3-18	33	0	0-43	287	5	3-10	112	6	2-13	35	0	0-87	169	4	2-9	175	2	0-6
COMMUNITY MEMORIAL HOSP SOUTH HILLS VA 23970	14	29	6-53	7	0	14-78	32	6	2-25	.	.		97	3	2-12	33	6	1-22	3	0	0-100	126	6	2-10	55	2	0-13
CULPEPER MEM HOSP INC CULPEPER VA 22701	5	20	8-79	14	7	11-58	17	6	1-34	9	0	0-100	53	4	2-17	37	11	2-21	3	0	0-100	35	0	1-18	46	2	0-16
DEPAUL HOSP NORFOLK VA 23505	13	15	5-53	8	25	16-77	67	13	3-18	31	3	0-40	271	4	3-9	106	4	1-12	21	0	0-83	170	4	2-9	107	1	0-7
DICKERSON COUNTY MED CNTR CLINTWOOD VA 24228	1	0	0-100	3	0	5-86	.	.		.	.		8	0	0-70	4	0	0-84	.	.		3	0	0-99	3	0	0-100
EASTERN STATE HOSP WILLIAMSBURG VA 23185	2	50	2-91	.	.		2	0	0-98	1	0	0-100	2	0	0-100	1	0	0-100	.	.		2	0	0-99	1	0	0-100
FAIR OAKS HOSP FAIRFAX VA 22033	4	25	1-76	8	50	8-66	27	15	2-27	4	0	0-100	82	7	1-12	50	6	2-19	3	0	0-100	72	1	1-12	68	1	0-10 8
FAIRFAX HOSP FALLS CHURCH VA 22046	22	5	6-46	21	29	19-61	88	5	4-17	76	0	0-15	307	3	2-8	115	3	1-12	34	0	0-57	495	5	2-7	191	3	0-5
FRANKLIN MEMORIAL HOSP ROCKY MOUNT VA 24151	4	50	4-79	7	57	13-76	2	0	0-95	.	.		49	2	1-15	11	18	2-45	1	0	0-100	40	5	1-18	10	10	0-68
GILES MEMORIAL HOSPITAL PEARISBURG VA 24134	.	.		5	60	11-81	.	.		.	.		42	2	1-17	7	0	0-59	3	0	0-100	48	4	1-15	9	11	0-50
GILL MEMORIAL EYE EAR NOSE ROANOKE VA 24011	.	.		.	.		.	.		71	1	0-19	.	.		.	.		.	.		1	0	0-100	.	.	
GREENSVILLE MEM HOSPITAL EMPORIA VA 23847	10	30	6-61	17	35	15-60	13	23	1-40	2	0	0-100	83	1	2-13	30	3	2-25	3	0	0-100	97	7	2-11	19	0	0-42
GRUNDY HOSP GRUNDY VA 24614	.	.		.	.		.	.		.	.		.	.		.	.		.	.		1	0	0-100	.	.	
HALIFAX COMMUNITY HOSP SOUTH BOSTON VA 24592	5	20	1-71	12	17	15-66	43	9	4-24	2	0	0-100	130	2	2-10	54	4	1-17	17	0	0-87	97	4	1-11	62	2	0-11
HAMPTON GENERAL HOSP HAMPTON VA 23669	23	30	8-48	21	43	18-60	47	15	3-21	3	0	0-100	185	7	2-9	77	4	1-14	20	5	0-76	140	6	2-10	138	3	0-6

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HENRICOS DOCTORS HOSP RICHMOND VA 23229	VA-37 *	2422	9	7-14	135	19	15-33	60	28	17-41	32	31	9-39	149	25	16-31	82	24	27-49	37	27	8-36	158	15	12-26
HIRIAM DAVIS MEM HOSP PETERSBURG VA 23803	VA-38	126	8	4-15	.	.		.	.		2	0	0-93	1	100	0-97	1	100	2-98	12	0	2-46	17	41	8-47
HOSPICE OF NORTHERN VA INC ARLINGTON VA 22205	VA-39 *	34	79	14-43	22	77	15-53	.	.		.	.		.	.		.	.		.	.		1	0	0-97
HUMANA HOSP BAYSIDE VIRGINIA BEACH VA 23455	VA-40	1253	13	9-15	81	37	15-37	49	16	17-43	28	18	4-33	74	32	13-32	45	13	22-51	54	24	9-34	107	16	13-30
HUMANA HOSP-ST LUKES RICHMOND VA 23229	VA-41	1322	11	8-15	82	28	14-36	51	18	18-43	38	32	9-37	74	20	15-35	43	26	23-52	26	19	10-44	90	22	12-30
HUMANA HOSPITAL CLINCH VAL RICHLANDS VA 24641	VA-42	1015	8	6-13	33	24	16-49	22	45	15-53	14	14	5-46	38	34	11-38	18	22	20-64	5	80	5-74	113	13	10-27
JEFFERSON MEMORIAL HOSPITA ALEXANDRIA VA 22302	VA-43	515	7	7-15	30	33	13-45	7	0	4-63	20	10	8-45	37	16	13-40	9	33	19-76	12	17	3-48	33	9	7-33
JOHN RANDOLPH HOSP HOPEWELL VA 23860	VA-44	995	12	9-16	54	31	10-34	40	15	16-44	17	24	8-48	72	15	13-33	37	35	23-55	51	24	8-33	119	16	14-30
JOHNSTON MEMORIAL HOSP ABINGDON VA 24210	VA-45	1143	14	8-15	59	27	14-38	30	27	14-46	27	30	8-39	54	24	11-33	32	50	22-55	28	21	8-41	163	27	13-27
JOHNSTON-WILLIS HOSPITAL RICHMOND VA 23231	VA-46	1638	11	9-16	124	23	18-37	78	19	18-38	35	17	7-35	76	22	14-33	49	29	25-53	32	28	14-47	147	20	11-26
KINGS DAUGHTERS HOSP STAUNTON VA 24401	VA-47	1601	12	8-15	113	34	15-34	68	31	19-42	36	19	9-38	69	26	13-33	65	29	25-49	23	26	4-37	160	20	11-26
LEE CO HOSP PENNINGTON GAP VA 24277	VA-48 *	656	11	9-17	11	55	16-69	24	38	15-51	8	13	3-57	34	18	11-39	24	21	21-59	17	35	8-49	125	13	14-30
LEIGH MEMORIAL MEDICAL CEN NORFOLK VA 23507	VA-49	2080	10	7-14	184	18	15-32	77	30	18-39	59	17	8-30	91	24	14-32	57	32	27-53	39	21	8-36	152	16	11-25
LEWIS-GALE HOSPITAL SALEM VA 24153	VA-50 *	3064	9	7-13	191	24	16-33	116	18	19-36	37	11	6-33	140	18	15-30	80	36	27-49	39	13	6-32	193	14	12-26
LONESOME PINE HOSP BIG STONE GAP VA 24219	VA-51 *	511	14	9-17	22	36	13-51	22	9	12-48	8	25	3-57	20	10	10-47	19	47	19-61	17	12	4-42	104	23	13-30
LOUDOUN MEMORIAL HOSPITAL LEESBURG VA 22075	VA-52 8	780	12	8-16	63	35	15-39	30	20	14-46	16	19	6-45	40	23	10-36	22	41	20-59	20	15	4-39	60	13	11-33
LOUISE OBICI MEM HOSP SUFFOLK VA 23434	VA-53 *	1568	12	9-15	98	36	18-38	73	11	15-36	33	15	4-31	111	21	13-29	50	38	25-53	47	17	7-32	157	18	12-27
LYNCHBURG GENL HOSP DIV CE LYNCHBURG VA 24506	VA-54 *	3100	13	9-15	222	32	17-33	150	31	20-36	59	22	11-34	195	19	16-29	118	37	29-48	62	19	8-31	286	17	13-25
MARTHA JEFFERSON HOSP CHARLOTTESVILLE VA 22901	VA-55	2346	12	8-15	164	26	17-35	101	28	19-37	49	31	8-32	118	19	15-31	85	38	30-52	41	24	6-32	245	22	13-25
MARY IMMACULATE HOSPITAL NEWPORT NEWS VA 23607	VA-56	511	11	7-15	21	24	14-54	30	33	15-48	7	14	2-59	32	31	10-39	13	54	18-68	14	21	3-45	34	15	7-34
MARY WASHINGTON HOSP FREDERICKSBURG VA 22401	VA-57	2702	13	10-16	184	36	18-35	105	27	20-38	66	27	11-33	175	25	17-31	77	44	28-51	68	18	8-31	322	21	15-27
MARYVIEW HOSPITAL PORTSMOUTH VA 23707	VA-58*	1987	13	8-15	157	33	17-34	93	32	19-38	34	21	8-36	111	21	14-31	54	46	25-52	41	10	6-32	143	19	12-27
MATTIE WILLIAMS HOSP RICHLANDS VA 24641	VA-59	370	9	6-15	5	60	5-73	19	26	13-53	9	33	7-61	15	40	7-49	12	33	16-67	12	8	2-46	46	2	7-29
MEDICAL COLLEGE OF VIRGINI RICHMOND VA 23219	VA-60	3212	11	8-14	310	22	18-33	102	31	18-36	56	21	6-28	133	19	15-30	111	21	27-46	43	30	11-38	186	22	14-27
MEMORIAL HOSP DANVILLE VA 24541	VA-61 *	3475	12	9-15	251	25	16-31	139	26	19-36	47	13	9-34	207	26	17-30	145	37	28-46	168	20	11-29	286	19	11-23
MEMORIAL HOSPITAL MARTINSV MARTINSVILLE VA 24112	VA-62	1937	13	8-15	121	32	16-35	60	38	16-39	36	14	6-32	127	20	14-29	71	49	27-50	49	20	10-36	186	20	13-26

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HENRICOS DOCTORS HOSP RICHMOND VA 23229	16	44	8-55	7	29	16-79	42	5	2-21	15	0	0-90	236	3	3-10	97	0	1-12	28	0	0-68	416	5	3-8	232	0	0-5
HIRIAM DAVIS MEM HOSP PETERSBURG VA 23803	1	0	1-97	3	0	2-82	.	.		1	0	0-100	1	0	0-100	2	0	0-99	.	.		3	0	0-94	.	.	
HOSPICE OF NORTHERN VA INC ARLINGTON VA 22205	1	100	0-98	.	.		.	.		.	.		3	100	2-81	.	.		.	.		.	.		2	50	0-89
HUMANA HOSP BAYSIDE VIRGINIA BEACH VA 23455	13	23	6-55	17	35	17-62	25	24	2-28	5	0	0-100	130	5	2-11	42	5	1-19	11	0	0-100	127	4	2-10	92	2	0-9
HUMANA HOSP-ST LUKES RICHMOND VA 23229	18	6	6-49	6	33	13-80	45	11	3-22	2	0	0-100	108	2	2-11	56	7	2-18	9	0	0-89	84	4	1-11	158	1	0-6 8
HUMANA HOSPITAL CLINCH VAL RICHLANDS VA 24641	6	0	1-66	1	0	1-97	9	33	1-50	7	0	0-100	138	5	2-10	48	2	1-18	7	0	0-100	117	2	2-10	63	2	0-11
JEFFERSON MEMORIAL HOSPITA ALEXANDRIA VA 22302	3	0	0-85	.	.		3	0	0-93	2	0	0-100	60	7	1-15	14	0	0-42	3	0	0-100	47	0	1-16	50	0	0-18
JOHN RANDOLPH HOSP HOPEWELL VA 23860	12	50	8-59	13	31	12-61	25	16	2-28	8	0	0-100	91	4	2-12	65	5	1-15	6	0	0-100	103	2	1-10	38	0	0-19 8
JOHNSTON MEMORIAL HOSP ABINGDON VA 24210	7	29	3-64	7	29	11-74	50	8	2-19	8	0	0-100	127	4	2-11	47	9	1-19	12	0	0-98	69	1	1-13	85	1	0-9
JOHNSTON-WILLIS HOSPITAL RICHMOND VA 23231	16	13	9-55	15	60	20-68	42	14	3-24	2	0	0-100	175	3	2-10	89	4	1-13	9	0	0-89	99	0	2-11	108	3	0-8 8
KINGS DAUGHTERS HOSP STAUNTON VA 24401	18	50	10-54	11	36	15-69	46	7	2-20	12	0	0-99	189	2	2-9	65	3	1-15	12	0	0-83	97	9	2-12	89	0	0-9
LEE CO HOSP PENNINGTON GAP VA 24277	4	50	7-82	.	.		16	13	1-36	.	.		75	1	1-12	14	21	1-38	5	0	0-100	68	7	1-13	23	9	0-29
LEIGH MEMORIAL MEDICAL CEN NORFOLK VA 23507	8	13	7-67	9	33	14-72	43	12	3-22	19	0	0-89	213	3	2-9	94	2	1-13	20	0	0-97	111	8	2-10	251	2	0-4
LEWIS-GALE HOSPITAL SALEM VA 24153	26	27	8-46	30	47	20-56	100	7	4-16	47	0	0-22	318	5	2-8	113	6	2-13	23	0	0-65	237	3	3-9	268	2	0-4 8
LONESOME PINE HOSP BIG STONE GAP VA 24219	5	60	8-79	4	25	4-79	9	0	1-50	.	.		70	3	1-13	19	5	2-33	5	0	0-100	44	9	1-16	20	0	0-55
LOUDOUN MEMDRIAL HOSPITAL LEESBURG VA 22075	8	25	9-69	3	33	3-84	24	17	3-32	5	0	0-100	72	7	2-14	52	2	1-17	5	20	0-98	66	9	1-13	58	0	0-12 8
LOUISE OBICI MEM HOSP SUFFOLK VA 23434	19	32	10-53	8	13	13-74	37	11	2-23	3	0	0-100	200	5	2-9	89	9	2-14	29	0	0-71	89	3	2-12	74	0	0-10
LYNCHBURG GENL HOSP DIV CE LYNCHBURG VA 24506	22	18	5-45	13	46	15-65	122	5	4-15	.	.		309	6	3-9	122	7	2-12	6	0	0-100	236	7	2-8	258	2	0-4 8
MARTHA JEFFERSON HOSP CHARLOTTESVILLE VA 22901	11	9	6-58	19	42	19-62	82	6	3-16	22	0	0-84	271	5	2-8	103	7	2-14	27	0	0-74	171	2	2-9	175	2	0-6
MARY IMMACULATE HOSPITAL NEWPORT NEWS VA 23607	4	0	0-80	4	50	8-83	12	0	0-43	11	0	0-94	63	2	1-14	11	9	1-44	1	0	0-100	40	3	1-17	63	0	0-13
MARY WASHINGTON HOSP FREDERICKSBURG VA 22401	22	18	7-47	47	32	22-53	55	7	4-21	41	0	0-33	284	4	3-9	111	4	1-12	21	0	0-86	237	2	2-8	126	2	0-7
MARYVIEW HOSPITAL PORTSMOUTH VA 23707	13	38	8-58	9	44	12-69	31	0	2-26	12	8	0-94	216	7	3-10	85	9	2-15	18	0	0-98	171	5	2-9	111	4	0-7
MATTIE WILLIAMS HOSP RICHLANDS VA 24641	2	100	3-92	.	.		3	0	0-86	1	0	0-100	59	5	2-16	14	0	0-47	1	0	0-100	56	0	1-14	14	0	0-57
MEDICAL COLLEGE OF VIRGINI RICHMOND VA 23219	74	12	6-35	4	50	4-77	57	19	3-19	92	0	0-11	140	9	3-11	104	13	1-13	20	0	0-93	383	5	3-8	179	0	0-5
MEMORIAL HOSP DANVILLE VA 24541	60	15	10-41	29	28	16-51	91	4	3-16	34	0	0-42	356	6	3-9	151	3	1-11	36	3	0-56	240	4	3-9	202	2	0-5
MEMORIAL HOSPITAL MARTINSV MARTINSVILLE VA 24112	32	34	11-47	17	47	16-61	54	4	3-19	6	0	0-100	221	3	1-8	162	4	1-11	22	0	0-83	95	8	1-10	125	2	0-7

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MONTGOMERY REGIONAL HOSPIT BLACKSBURG VA 24060	VA-63 *	1010	11	8-15	48	31	14-40	23	13	13-49	18	17	4-40	66	20	13-34	26	31	20*57	40	23	6-33	110	18	11-28
MOUNT VERNON HOSP ALEXANORIA VA 22306	VA-64	1007	8	7-14	60	28	12-36	32	22	12-43	23	17	5-38	52	12	13-36	31	35	21-55	28	14	5-36	82	10	11-30
NATL ORTHOPAEOICREHAB HOS ARLINGTON VA 22206	VA-65 *	762	5	3-10	4	25	1-74	19	32	12-51	12	25	3-46	17	18	7-46	13	38	17-66	6	0	2-64	41	22	7-32
NEWPORT NEWS GENL HOSPITAL NEWPORT NEWS VA 23605	VA-66 *	334	14	7-17	17	18	11-52	21	24	14-52	11	0	2-47	17	6	5-41	10	60	16-71	23	35	6-40	19	5	4-37
NORFOLK COMM HOSP NORFOLK VA 23504	VA-67 *	569	10	7-15	38	21	10-38	29	7	12-44	9	22	2-53	38	16	10-37	13	46	15-64	27	11	6-37	43	21	6-29
NORFOLK GENERAL HOSPITAL NORFOLK VA 23507	VA-68	4151	11	7-14	411	29	19-33	146	32	19-35	57	11	6-27	159	19	15-29	104	34	25-45	89	17	9-30	191	18	12-25
NORTHAMPTON ACCOMACK MEMOR NASSAWAOOX VA 23413	VA-69 *	1284	15	9-16	98	36	15-36	79	29	17-38	29	17	8-39	55	15	13-36	56	41	28-54	34	18	9-39	111	23	10-26
NORTHERN VA OOCTORS HOSP ARLINGTON VA 22204	VA-70 *	1299	10	8-15	111	22	11-30	44	30	18-45	28	7	7-37	73	23	14-34	48	27	26-54	29	17	11-44	87	15	10-28
NORTON COMMUNITY HOSP NORTON VA 24273	VA-71 *	850	11	8-15	18	56	18-61	17	35	13-55	13	15	3-46	29	38	11-42	32	38	21-54	35	14	10-40	109	17	11-28
PAGE MEMORIAL HOSPITAL LURAY VA 22835	VA-72 *	310	12	9-18	13	46	7-52	8	13	7-64	7	0	3-62	25	12	10-43	17	41	21-66	15	7	3-42	51	12	11-35
PORTSMOUTH GENERAL HOSP PORTSMOUTH VA 23704	VA-73 *	1278	14	9-16	82	22	12-32	49	22	17-43	48	8	7-31	69	26	14-35	35	51	21-53	40	20	8-35	99	36	12-29
POTOMAC HOSPITAL WOODBRIOGE VA 22191	VA-74	706	9	7-15	35	20	9-38	18	6	11-51	16	19	5-45	40	18	10-35	28	29	23-58	21	5	2-36	72	11	9-29
PRINCE WILLIAM HOSP MANASSAS VA 22110	VA-75	901	13	8-15	51	22	11-36	41	12	15-42	24	29	6-39	44	18	11-35	26	19	21-58	29	31	8-40	104	24	11-27
PULASKI COMMUNITY HOSP PULASKI VA 24301	VA-76 *	971	10	8-15	49	47	19-46	46	37	19-46	14	7	3-43	60	18	14-36	27	15	23-60	11	9	1-48	67	9	11-31
R J REYNOLOS-PATRICK CO ME STUART VA 24171	VA-77 *	410	12	8-16	7	14	5-65	20	25	12-50	10	10	2-50	21	52	10-47	14	14	14-61	32	19	6-35	46	17	10-34
RAOFORO COMMUNITY HOSP RAOFORO VA 24141	VA-78	1140	12	8-15	59	31	14-39	47	28	17-43	19	16	6-43	51	31	13-36	48	46	25-53	57	21	7-31	95	17	10-27
RAPPAHANNOCK GEN HOSP KILMARNOCK VA 22482	VA-79 *	943	11	8-15	70	33	16-39	25	28	12-47	28	4	5-34	55	13	13-35	33	39	24-57	16	38	8-51	56	18	9-31
RESTON MED CNTR RESTON VA 22090	VA-80	262	6	7-17	23	9	6-40	6	33	8-73	10	20	12-66	12	17	8-55	6	33	10-76	5	20	7-76	27	0	7-37
RETREAT HOSPITAL RICHMONO VA 23220	VA-81	1957	9	7-14	180	29	16-32	62	26	18-41	39	8	5-30	67	13	12-32	38	26	24-55	41	17	9-37	137	16	13-28
RICHMONO COMMUNITY HOSP RICHMONO VA 23223	VA-82 *	518	10	6-14	26	31	12-46	21	24	11-48	17	18	4-40	22	27	8-41	5	20	7-76	37	14	9-38	29	14	7-36
RICHMONO EYE ANO EAR HOSP RICHMONO VA 23219	VA-83 *	255	0	0-21	1	0	0-99	.	.		.	.		.	.		.	.		.	.		.	.	
RICHMONO MEMORIAL HOSP RICHMONO VA 23227	VA-84	2936	12	8-15	195	29	15-32	134	33	20-36	73	15	8-28	149	20	16-30	78	32	27-49	95	20	11-31	243	20	13-25
RICHMONO METROPOLITAN HOSP RICHMONO VA 23220	VA-85 *	856	8	8-15	54	22	14-39	23	26	12-48	11	9	2-47	40	10	10-36	13	31	15-64	31	10	9-40	66	17	12-34
RIVERSIOE HOSPITAL NEWPORT NEWS VA 23601	VA-86	3595	13	8-14	392	32	18-32	129	32	19-36	80	9	8-27	170	23	15-28	143	42	27-45	62	29	7-30	207	17	12-26
ROANOKE MEMORIAL HOSP ROANOKE VA 24014	VA-87	4154	12	8-14	359	33	21-35	140	26	19-35	85	11	7-26	186	19	15-28	119	39	27-46	66	30	12-35	271	18	13-25
ROCKINGHAM MEM HOSP HARRISONBURG VA 22801	VA-88 *	2426	12	8-15	184	27	17-34	86	26	19-39	49	22	9-33	135	22	17-32	77	38	26-49	51	18	8-33	214	14	14-27

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
MONTGOMERY REGIONAL HOSPIT BLACKSBURG VA 24060	11	9	7-59	5	60	11-82	31	6	2-25	9	0	0-100	145	6	2-11	39	5	1-20	8	0	0-100	87	3	1-11	45	2	0-15
MOUNT VERNON HOSP ALEXANDRIA VA 22306	5	0	1-60	2	0	2-90	29	14	4-30	2	0	0-100	91	3	2-13	43	2	1-19	10	0	0-89	67	4	1-13	56	0	0-12
NATL ORTHOPAEDICREHAB HOS ARLINGTON VA 22206	3	67	1-82	3	0	2-83	45	2	3-21	.	.		25	4	1-24	8	0	0-73	.	.		30	0	0-21	295	1	0-4
NEWPORT NEWS GENL HOSPITAL NEWPORT NEWS VA 23605	5	40	2-71	6	17	6-70	4	0	1-74	1	0	0-100	22	5	1-27	12	0	0-42	1	0	0-100	27	4	1-22	14	0	0-43
NORFOLK COMM HOSP NORFOLK VA 23504	15	20	8-56	4	25	6-81	5	20	1-67	9	0	0-100	57	11	1-15	32	0	1-22	4	0	0-97	49	4	1-15	34	0	0-22
NORFOLK GENERAL HOSPITAL NORFOLK VA 23507	43	12	6-39	18	61	18-82	80	23	4-18	177	1	0-5	255	7	3-9	144	1	2-12	24	4	0-47	656	6	3-7	211	2	0-5
NORTHAMPTON ACCOMACK MEMOR NASSAWADOX VA 23413	13	38	6-55	9	33	13-70	28	4	2-26	2	0	0-100	135	4	2-11	68	12	2-17	8	0	0-100	95	3	1-11	59	10	0-12
NORTHERN VA DOCTORS HOSP ARLINGTON VA 22204	11	36	9-62	17	24	20-65	31	10	2-25	19	0	0-68	137	6	2-11	84	7	2-14	8	0	0-94	88	5	2-12	69	7	0-11
NORTON COMMUNITY HOSP NORTON VA 24273	7	14	4-65	5	60	9-79	14	0	1-39	9	0	0-100	84	4	3-14	55	7	2-18	1	0	0-100	107	3	2-11	41	0	0-16
PAGE MEMORIAL HOSPITAL LURAY VA 22835	6	33	1-66	2	0	1-89	7	14	0-59	.	.		35	3	1-19	9	33	0-52	3	0	0-100	25	4	0-24	11	0	0-60
PORTSMOUTH GENERAL HOSP PORTSMOUTH VA 23704	10	30	5-59	51	47	24-54	25	16	3-31	12	8	0-96	115	6	2-11	63	3	1-16	11	9	0-87	101	7	2-11	49	4	0-15
POTOMAC HOSPITAL WOODBRIDGE VA 22191	7	0	1-63	10	30	11-65	22	9	1-28	2	0	0-100	76	3	1-13	21	0	0-31	4	25	0-92	72	4	1-12	41	0	0-21
PRINCE WILLIAM HOSP MANASSAS VA 22110	11	27	8-61	11	55	12-64	19	11	1-31	10	0	0-100	101	6	2-12	37	5	1-21	6	0	0-100	59	8	1-14	48	0	0-14 8
PULASKI COMMUNITY HOSP PULASKI VA 24301	13	23	11-62	9	11	10-65	3	0	0-93	13	0	0-91	131	5	2-10	46	7	1-19	5	0	0-96	130	4	2-10	38	0	0-24 8
R J REYNOLDS-PATRICK CO ME STUART VA 24171	6	33	3-68	4	25	4-78	9	0	1-50	.	.		52	8	1-16	8	13	0-65	3	0	0-100	40	3	1-18	12	0	0-86
RADFORD COMMUNITY HOSP RADFORD VA 24141	16	0	3-48	5	0	8-78	46	7	3-22	6	0	0-100	136	5	2-11	49	2	1-17	17	0	0-99	87	5	2-12	66	3	0-11
RAPPAHANNOCK GEN HOSP KILMARNOCK VA 22482	5	20	6-76	9	67	13-70	32	9	2-25	.	.		100	4	2-11	45	7	1-19	7	0	0-100	54	4	2-16	99	2	0-8
RESTON MED CNTR RESTON VA 22090	6	33	6-72	.	.		2	0	0-99	1	0	0-100	48	0	2-17	21	5	0-30	1	0	0-100	13	0	0-39	19	0	0-74
RETREAT HOSPITAL RICHMOND VA 23220	15	33	12-61	14	29	13-61	43	9	2-21	22	0	0-92	230	1	2-8	104	2	1-12	30	0	0-75	140	4	2-10	267	1	0-4
RICHMOND COMMUNITY HOSP RICHMOND VA 23223	3	33	3-64	4	50	7-82	2	0	0-99	.	.		47	4	2-18	12	17	1-42	2	0	0-100	84	7	1-11	15	0	0-65
RICHMOND EYE AND EAR HOSP RICHMOND VA 23219	1	0	1-97	.	.		.	.		202	0	0-4	.	.		.	.		.	.		1	0	0-100	2	0	0-100
RICHMOND MEMORIAL HOSP RICHMOND VA 23227	32	25	9-45	41	22	22-54	75	13	4-19	.	.		292	7	2-8	120	5	2-12	26	0	0-77	243	6	2-8	134	4	0-7
RICHMOND METROPOLITAN HOSP RICHMOND VA 23220	15	33	8-54	22	18	18-58	9	11	1-50	.	.		63	6	1-14	27	7	2-27	8	0	0-100	63	3	1-14	47	0	0-18
RIVERSIDE HOSPITAL NEWPORT NEWS VA 23601	31	26	7-42	24	38	17-55	94	4	3-15	22	0	0-81	335	5	3-9	96	3	1-13	35	0	0-34	326	6	2-7	265	1	0-4
ROANOKE MEMORIAL HOSP ROANOKE VA 24014	32	31	7-43	33	27	19-53	92	13	3-16	9	0	0-100	337	7	3-8	141	2	2-12	42	0	0-35	474	5	3-7	239	2	0-5
ROCKINGHAM MEM HOSP HARRISONBURG VA 22801	32	19	8-43	19	26	15-57	73	4	2-16	15	0	0-99	294	5	2-8	117	2	1-12	38	0	0-29	170	5	2-9	143	0	0-6

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
RUSSELL CO HOSP LEBANON VA 24266	VA-89 *	582	12	8-16	15	27	11-56	18	44	15-56	14	14	5-47	20	35	8-44	35	37	23-55	7	14	1-59	76	25	12-31
SHENANDOAH CO MEMORIAL HOS WOODSTOCK VA 22664	VA-90 *	673	14	9-17	43	35	12-39	45	31	16-43	20	5	5-39	53	26	11-34	26	65	21-58	4	25	3-77	74	11	9-28 8
SMYTH COUNTY COMM HOSP MARION VA 24354	VA-91 *	1061	14	9-16	61	38	16-40	40	30	16-44	19	32	5-41	57	19	14-37	54	46	25-51	68	16	9-31	129	20	12-28
SOUTHAMPTON MEM HOSP FRANKLIN VA 23851	VA-92 *	665	12	9-17	27	41	18-54	29	38	15-48	20	10	5-41	45	13	13-38	29	38	21-56	19	5	3-38	69	28	12-32
SOUTHSIDE COMM HOSP FARMVILLE VA 23901	VA-93	951	15	9-16	58	22	9-32	36	33	14-43	40	13	5-30	61	26	13-34	35	34	26-58	40	23	9-37	120	28	13-29
SOUTHSIDE REGIONAL MEDICAL PETERSBURG VA 23803	VA-94	2289	13	9-15	119	22	14-33	92	36	19-38	58	9	7-28	166	26	16-30	70	37	25-48	97	30	11-32	198	23	13-27
SOUTHWESTERN STATE HOSP MARION VA 24354	VA-95 *	66	3	2-17	1	0	3-100	.	.		.	.		.	.		.	.		3	0	0-85	11	18	4-50
ST MARY S HOSPITAL OF RICH RICHMOND VA 23226	VA-96	2586	10	9-15	243	26	16-32	80	24	18-39	49	18	9-33	106	23	15-32	88	40	28-50	60	10	9-33	184	15	14-28
ST MARYS HOSP NORTON VA 24273	VA-97 *	431	10	7-15	14	43	7-51	14	21	11-56	5	20	3-70	14	29	7-51	14	29	18-65	3	33	2-81	46	15	11-36
STONEWALL JACKSON HOSPITAL LEXINGTON VA 24450	VA-98 *	560	11	7-15	22	32	5-38	13	15	11-57	28	11	4-33	23	9	8-41	27	26	22-58	18	11	5-43	70	21	11-32
STUART CIRCLE HOSPITAL RICHMOND VA 23220	VA-99 *	1430	11	8-15	127	21	14-32	69	29	17-39	41	20	9-36	63	21	14-36	28	29	21-57	20	25	9-47	108	21	11-28
TAZEWELL COMM HOSP TAZEWELL VA 24651	VA-100*	431	9	7-16	17	18	13-56	8	13	6-61	11	9	5-53	28	32	9-40	17	24	16-60	16	31	6-46	37	24	8-34
THE FAUQUIER HOSPITAL WARRENTON VA 22186	VA-101	874	13	9-17	45	22	11-37	33	33	17-48	23	30	5-38	72	25	14-34	32	44	25-59	23	17	9-45	78	12	12-32
TIDEWATER MEMORIAL HOSP TAPPAHANNOCK VA 22560	VA-102*	482	15	9-18	11	27	7-57	14	21	10-55	11	18	5-53	25	8	8-39	25	52	21-58	15	20	6-48	53	11	10-33
TWIN COUNTY COMMUNITY HOSP GALAX VA 24333	VA-103*	1364	11	8-15	59	41	19-44	40	28	16-44	21	10	7-42	62	18	12-32	50	44	23-51	29	10	5-35	142	18	12-27
UN OF VA HOSP CHILDRENS CHARLOTTESVILLE VA 22901	VA-104	3596	10	7-14	324	23	21-36	109	24	19-37	52	13	7-30	95	20	15-32	104	40	27-47	58	22	7-31	204	19	13-27
US ARMY HOSP FORT LEE VA 23801	VA-105*	1	0	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
VIRGINIA BAPTIST HOSP OIV LYNCHBURG VA 24503	VA-106	1804	9	7-14	188	24	14-30	42	17	15-43	42	12	10-36	57	21	12-34	46	41	25-53	30	13	5-35	124	15	11-27
VIRGINIA BEACH GENERAL HOS VIRGINIA BEACH VA 23454	VA-107	1960	11	8-15	155	24	17-35	58	14	19-43	40	28	8-35	79	20	16-35	59	39	26-51	40	28	7-35	190	21	12-26
WALTER REED MEMORIAL HOSPI GLOUCESTER VA 23061	VA-108*	753	16	10-18	56	41	17-42	32	19	13-44	23	13	8-42	46	17	13-38	39	51	24-55	16	25	8-51	77	27	10-30
WARREN MEMORIAL HOSPITAL FRONT ROYAL VA 22630	VA-109	604	14	8-16	41	22	14-42	28	29	15-48	11	27	6-54	30	30	9-39	25	48	19-55	8	25	2-57	43	16	9-33
WAYNESBORO COMMUNITY HOSPI WAYNESBORO VA 22980	VA-110*	1186	13	8-15	67	36	13-36	49	39	18-44	17	12	6-45	76	25	13-32	66	41	26-50	41	17	9-36	102	16	11-28
WESTERN STATE HOSP STAUNTON VA 24401	VA-111*	112	9	6-19	2	50	0-91	1	0	0-99	4	0	0-75	.	.		.	.		11	9	4-52	25	16	7-39
WILLIAMSBURG COMMUNITY HOS WILLIAMSBURG VA 23185	VA-112	942	10	8-15	78	27	16-38	32	9	13-43	23	17	5-38	43	14	11-36	35	29	23-55	18	33	7-46	60	15	10-31
WINCHESTER MEDICAL CENTER WINCHESTER VA 22601	VA-113	3041	10	8-14	220	32	17-33	123	24	18-34	52	15	7-30	207	16	16-28	95	34	27-48	45	13	6-31	221	17	13-26
WISE APPALACHIAN REGIONAL WISE VA 24293	VA-114*	403	9	7-15	15	27	13-59	8	13	8-66	6	0	1-63	19	32	10-48	15	33	16-62	14	14	5-48	55	11	7-28

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
RUSSELL CO HOSP LEBANON VA 24266	11	9	3-61	4	25	4-78	5	20	0-71	1	0	0-100	59	1	2-15	16	0	0-36	3	0	0-100	88	3	1-11	10	0	0-69
SHENANDOAH CO MEMORIAL HOS WOODSTOCK VA 22664	7	0	4-55	8	38	8-66	26	4	2-27	.	.		63	5	2-15	32	3	1-22	5	0	0-55	49	6	1-16	47	2	0-15
SMYTH COUNTY COMM HOSP MARION VA 24354	3	33	6-87	3	67	5-95	31	23	2-24	23	0	0-70	125	3	2-10	49	6	2-19	13	0	0-100	62	5	2-12	31	0	0-32
SOUTHAMPTON MEM HOSP FRANKLIN VA 23851	3	33	4-88	16	25	15-61	25	0	3-29	2	0	0-100	63	2	1-13	24	4	1-27	7	0	0-97	51	2	2-13	16	0	0-59
SOUTHSIDE COMM HOSP FARMVILLE VA 23901	12	17	6-57	12	33	15-57	18	11	1-32	1	0	0-100	100	5	2-12	73	3	1-14	16	0	0-82	78	9	1-12	30	0	0-37
SOUTHSIDE REGIONAL MEDICAL PETERSBURG VA 23803	26	19	7-45	28	39	20-57	40	8	2-21	38	0	0-48	168	5	3-10	132	2	2-12	15	0	0-87	168	7	2-9	99	1	0-8
SOUTHWESTERN STATE HOSP MARION VA 24354	.	.		.	.		.	.		.	.		1	0	0-100	2	0	0-84	.	.		.	.		.	.	
ST MARY S HOSPITAL OF RICH RICHMOND VA 23225	25	20	15-56	38	42	20-53	53	5	2-17	9	11	0-100	275	2	2-8	123	5	1-12	22	0	0-87	153	4	2-9	194	1	0-5
ST MARYS HOSP NORTON VA 24273	2	0	5-84	5	20	7-76	10	10	0-47	.	.		43	5	2-20	23	4	1-27	3	0	0-100	55	5	1-14	10	0	0-80
STONEWALL JACKSON HOSPITAL LEXINGTON VA 24450	4	25	3-77	3	33	2-83	18	6	1-33	.	.		86	7	1-11	9	11	0-59	3	0	0-100	25	8	0-24	21	0	0-49
STUART CIRCLE HOSPITAL RICHMOND VA 23220	11	27	7-59	10	50	18-75	29	7	4-29	3	0	0-100	147	5	2-11	54	6	1-15	30	0	0-81	92	5	2-12	139	0	0-6
TAZEWELL COMM HOSP TAZEWELL VA 24651	4	0	0-82	8	63	15-75	4	0	0-79	.	.		51	2	1-13	16	0	1-35	1	0	0-100	31	0	1-20	26	4	0-31
THE FAUQUIER HOSPITAL WARRENTON VA 22186	12	10	3-56	10	40	14-69	25	4	1-27	2	0	0-100	87	5	3-14	36	6	1-21	3	0	0-100	85	5	2-12	53	2	0-11
TIDEWATER MEMORIAL HOSP TAPPAHANNOCK VA 22560	5	60	4-74	18	28	15-57	12	8	3-47	.	.		45	2	2-18	16	6	1-35	5	0	0-100	42	10	1-17	14	7	0-53
TWIN COUNTY COMMUNITY HOSP GALAX VA 24333	7	0	4-65	6	0	7-73	52	8	4-22	3	0	0-100	176	6	2-10	72	10	3-17	4	0	0-100	139	3	2-10	74	1	0-10
UN OF VA HOSP CHILDRENS CHARLOTTESVILLE VA 22901	51	14	7-38	11	55	13-66	55	20	4-21	167	0	0-5	207	6	3-11	93	6	1-13	21	0	0-44	405	6	4-9	173	1	0-5
US ARMY HOSP FORT LEE VA 23801	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
VIRGINIA BAPTIST HOSP DIV LYNCHBURG VA 24503	15	11	4-47	17	18	18-64	5	33	1-62	15	0	0-90	223	5	2-9	70	1	1-14	23	4	0-28	130	0	2-10	91	4	0-9
VIRGINIA BEACH GENERAL HOS VIRGINIA BEACH VA 23454	14	7	4-51	11	45	11-63	55	4	3-20	9	0	0-100	195	5	3-10	75	9	2-15	15	0	0-90	175	6	3-10	153	2	0-6
WALTER REED MEMORIAL HOSPI GLOUCESTER VA 23061	9	11	9-66	15	20	14-60	25	0	2-27	5	0	0-100	70	10	2-15	32	13	1-23	7	0	0-100	57	4	1-13	29	3	0-21
WARREN MEMORIAL HOSPITAL FRONT ROYAL VA 22630	7	14	5-68	5	20	8-72	24	21	2-30	1	0	0-100	53	3	1-14	25	8	0-25	5	0	0-100	54	6	1-15	35	0	0-23
WAYNESBORO COMMUNITY HOSP WAYNESBORO VA 22980	3	67	2-83	8	50	5-62	32	6	2-24	.	.		133	5	2-10	43	4	1-18	6	0	0-100	82	5	1-12	103	1	0-8
WESTERN STATE HOSP STAUNTON VA 24401	2	50	6-95	1	100	0-97	.			.	.		.	.		2	0	0-90	.	.		4	25	0-77	2	0	0-100
WILLIAMSBURG COMMUNITY HOS WILLIAMSBURG VA 23185	15	13	9-55	7	29	11-74	29	7	1-24	3	0	0-100	117	5	2-11	51	0	1-17	8	0	0-100	71	3	1-12	69	0	0-11
WINCHESTER MEDICAL CENTER WINCHESTER VA 22601	21	38	9-50	31	39	15-51	78	4	4-18	11	0	0-100	248	3	2-8	138	3	1-11	28	0	0-83	249	3	2-8	257	1	0-4
WISE APPALACHIAN REGIONAL WISE VA 24293	4	0	1-75	2	0	3-92	15	13	1-55				45	7	1-18	20	5	1-30	2	0	0-100	42	5	1-15	31	3	0-24

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																							
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WYTHE CNTY COMM HOSP WYTHEVILLE VA 24382	VA-115	632	14	11-19	15	27	14-59	34	21	16-46	12	25	6-52	52	23	10-33	27	44	25-61	34	12	8-38	131	16	13-29
WYTHEVILLE HOSP CORP WYTHEVILLE VA 24382	VA-116*	135	6	5-17	1	0	0-98	1	100	1-97	1	0	1-97	8	0	5-61	3	33	5-86	1	0	0-99	27	7	6-36

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Oisease			Sepsis			Severe Trauma			Ophthalmology			GI Oisease			Urology			Gynecology			Low Risk Heart Oisease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WYTHE CNTY COMM HOSP WYTHEVILLE VA 24382	8	50	5-64	5	60	12-83	1	0	0-98	2	0	0-100	63	10	2-15	22	5	1-28	1	0	0-100	43	2	1-17	17	0	0-41
WYTHEVILLE HOSP CORP WYTHEVILLE VA 24382	1	0	2-98	.	.		4	0	0-81	.	.		24	4	0-25	3	0	0-84	.	.		8	25	0-57	6	0	0-82

*Written Comments Not Submitted.

THE ALEXANDRIA HOSPITAL

4320
SEMINARY
ROAD
ALEXANDRIA
VIRGINIA
22304
703 379 3000

October 26, 1987

Mr. William Roper
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Roper:

The Alexandria Hospital is a 414-bed, acute care not-for-profit, full service, community hospital governed by a Board of Directors who serve voluntarily and represent the residents of the community. The Hospital admits over 15,000 patients a year and handles over 65,000 outpatient visits annually. Alexandria Hospital's services include a 24-Hour Emergency Department with a Level II Trauma Center, a Coronary Care Unit, an Oncology Unit, an Intensive Care Unit, a Level II Neonatal Intensive Care Unit, a Dialysis Unit, a Cardiac Catherization Lab, Interventional Radiology, OB/GYN Services and Psychiatry. In addition to this full range of services the Hospital also provides for community-oriented Family Centered Education Programs, Wellness Classes, a new Birthing Center, Outreach Laboratory Services, Senior Health Care Services, and a Physician Referral and Appointment Service. The Hospital, which serves approximately 325,000 people in Alexandria and surrounding areas, offers care to all regardless of their ability to pay. In fact, the Hospital provided over $2 million in services to the indigent population in 1986 alone. In addition, based on information in the 1986 Federal Register, the severity level of patients at the Alexandria Hospital was the third highest of the eight Northern Virginia hospitals.

Alexandria Hospital does not rely primarily on outside agencies for data to measure the quality of patient care. Regardless of statistics, the Hospital performs internal monitoring through an effective quality assurance plan. During the actual admission process, any breakdown in the standard of care can be corrected at that time, rather than

waiting to recognize a problem after discharge. This plan combines the ongoing monitoring of services rendered to the patient with the clinical expertise of the physicians. Thus, a system of comprehensive patient care evaluation is developed which ensures that the caliber of care we provide to our patients maintains the highest standard. The program is subject to the scrutiny of the Board of Directors as well as the Board's Professional Services Committee.

Alexandria Hospital's quality assurance plan meets the requirements of the Joint Commission on the Accreditation of Healthcare Organizations under which the Hospital is fully accredited. A hospital must demonstrate compliance with the pre-established guidelines of Joint Commission to receive this accreditation which signifies that the hospital is functioning well within the accepted standard of care of the healthcare community.

Upon our analysis of the mortality data provided by HCFA, we noted certain discrepancies. For example, HCFA indicated that the data had been prepared based on the last admission for an individual beneficiary. However, six patients said to have expired after discharge from our facility actually expired during a hospitalization that occurred subsequent to the admission listed in the report. In fact, the HCFA data does not actually reflect the last admission for these six Medicare recipients. Rationale for these data errors cannot be determined at the hospital level.

Since mortality is but one indicator and perhaps does not reflect hospital performance, our facility would like to comment on suggestions about releasing such information to the public.

It is important that the information be presented in laymen terms. An explanation of each diagnostic category is essential; for example, Cerebrovascular Accident means Stroke. This information should also help the public to understand that the data is based on diagnostic groupings determined by the principal reason for admission to the hospital. Other or accompanying medical conditions may have no bearing on the diagnostic category assigned. For instance, a patient with cancer or heart trouble who is admitted because of a fall which resulted in a broken hip is grouped in the same category as an otherwise well person who breaks a hip and is admitted. **The importance of the number of patients in each category should also be included in the explanation. It should be noted that categories with less than 100 patients may not be statistically significant.**

We appreciate this opportunity to respond to the proposed release of data. We believe that HCFA's release of information should take place only after analysis and that this release should be in the form of information rather than raw data to best avoid misinterpretation.

Sincerely,

J. Edward Sweet, Jr.

J. Edward Sweet, Jr.
President

Enclosure

ATTACHMENT 5

Alexandria Hospital

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	34	08	36	06
CE -- Cerebrovascular Accidents	12	00	12	00
GC -- Gastrointestinal Catastrophes	06	01	07	00
GI -- Gastrointestinal Disease	08	01	08	01
GU -- Urologic Disease	01	01	01	01
GY -- Gynecologic Disease	00	00	00	00
HL -- Low Risk Heart Disease	05	01	05	01
HM -- Severe Chronic Heart Disease	20	03	20	03
HS -- Severe Acute Heart Disease	17	00	17	00
ME -- Metabolic/Electrolyte Disturbances	04	00	04	00
OP -- Orthopedic Disorders	01	01	01	01
PN -- Pulmonary Disease	17	04	17	04
RN -- Renal Disease	04	00	04	00
SE -- Sepsis	07	00	07	00
TR -- Severe Trauma	02	02	02	02
OP -- Ophthalmalogic Disease	00	00	00	00
UN -- Other Diagnoses	25	08	28	05
Total -- All Categories	163	30	169	24

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30 days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

THE ARLINGTON HOSPITAL
1701 NORTH GEORGE MASON DRIVE • ARLINGTON, VIRGINIA 22205 • 703/558-5000

The Arlington Hospital - Medicare Provider 490050
Subject: Hospital Analysis of Medicare Mortality Data for 1986

The Arlington Hospital supports the concept of a well informed public and appreciates the opportunity to help ensure the accuracy of the data to be released.

Of concern to us is the limited value of counting the number of Medicare deaths, and attempting to determine quality from these statistics. This data does not consider such factors as the patient's condition on admission, severity of illness and if a patient was transferred from another facility.

Mortality review is an integral part of The Arlington Hospital's internal quality assurance program. Each death is reviewed by a group of physicians in the relevant specialty. This is part of the peer review process where review usually confirms that care was appropriate, even though death resulted.

It is important to note that mortality review is only one small part of a much larger quality assurance effort. Included in our comprehensive program are tissue review, surgical case appropriateness monitoring, pharmacy and therapeutics monitoring, medical records evaluation, blood use monitoring, infection surveillance, screening for unexpected clinical occurrences, review of the utilization of hospital ancillary and clinical support services, analysis of and response to surveys, assessments, inspections, etc. by external accreditation licensing, regulatory and reimbursement authorities, surveillance of equipment maintenance programs, and continuing medical health professional education based on demonstrated need.

This type of review covers all services and includes inpatient as well as outpatient care. Information is gathered on an ongoing basis. We systematically draw conclusions from the data gathered, make recommendations, take action and follow-up on the success of that action. The results of our quality assurance activity are used in the renewal of medical staff privileges.

Although The Arlington Hospital's mortality rates fall well within HCFA's "range of predicted mortality rates" for each diagnostic category, there are several areas where further elaboration would be useful:

Cancer (CA)

Our cancer patients were all in the end stages of the disease upon admission. Most were patients of, or were seen in consult by, our Oncology Specialist Physicians. Palliative treatment and comfort measures were provided so the patients would be as comfortable as possible during their last days.

Because Arlington Hospital has a high quality comprehensive cancer program, it is not surprising that cancer patients seek treatment here. Our 27 bed inpatient oncology unit provides one-to-one nursing care for patients undergoing chemotherapy. We provide a number of educational and emotional support groups and a full time social worker is available to our patients. Our Radiation Therapy Department is one of the finest in the area.

Stroke (CE)

The average age of the patients who died from cerebrovascular accidents (strokes) was 78. Every one of these patients had comorbidities (several medical problems), and many were terminal on admission. Also, it is important to remember that heart disease is the number one cause of death in the United States.

Metabolic and Electrolyte Disorders (ME)

The Arlington Hospital utilizes diagnostic codes according to the Medical Society of Virginia Review Organization guidelines, which require coding by principal diagnosis rather than cause of death. Coding this way may not always reflect the actual cause of death and, therefore, can be misleading. For example, 19 deaths in the category Metabolic/Electrolyte Disturbances (ME) had a principal diagnosis of dehydration; however, 15 of the 19 had end stage cancer.

RN (Renal Disease)

A small sample size (few patients in the diagnostic category) can be misleading. In the case of Renal Disease, The Arlington Hospital had only eight patients, two of whom died, prompting a 25 percent mortality rate. This sample size is not significant enough to make the mortality rate reliable.

Of the patients in this study, 34 did not die in the hospital. Based on review of each patient's record, we determined that all were stable at discharge. The majority of these patients were terminal when they left the hospital. They chose to go home, to a hospice or to a nursing home for their final days.

Consumers also should be reminded that the mortality data is for Medicare patients only and does not reflect a hospital's overall mortality rate. The Arlington Hospital's mortality rate for <u>all</u> patients in 1986 was 2.2%.

In addition, the Medical Society of Virginia Review Organization regularly reviews a sample of our Medicare cases and in fact reviewed many of the mortalities in this study. Medical care at Arlington Hospital was found to be appropriate in all of these cases.

Based on the results of our overall quality assurance program, we are confident that The Arlington Hospital provides quality care to our patients.

CHESAPEAKE
GENERAL HOSPITAL

Comments in Response to 1986 HCFA Mortality Data Release

(Medicare Provider #490120)

It is important to note that, while HCFA data is adjusted for some variables, adjustments have not been made for severity of illness. This hospital is flanked by several nursing homes, which refer many of their very elderly and debilitated patients to us when they develop acute problems. Often, these patients have respiratory conditions in addition to other illnesses. These factors should be taken into consideration when mortality data is evaluated. Also, this selected information relates ONLY to Medicare patients.

Since quality of care is always of utmost concern, patient-related data received is incorporated into the hospital's quality review program. Any potential problem areas are investigated and prompt corrective action is taken if concerns are, indeed, identified.

HCA Chippenham Hospital

October 26, 1987

William L. Roper, M.D.
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

RE: Chippenham Hospital Provider Number = 490112
Hospital Mortality Information

Dear Dr. Roper:

The data presented by HCFA indicates 2785 Medicare cases for Chippenham Hospital in 1986, of which 267 were listed as having died within 30 days of admission to our facility. Of the 267 deaths, 48 were listed as having died after discharge.

Our records show that Chippenham Hospital had 4816 Medicare admissions in 1986. The discrepancy between this figure and 2785 as listed by HCFA is due to the fact that HCFA only counted the last admission to the facility.

After reviewing the 267 HCFA list of deaths, we have verified that 223 patients on the list had died at Chippenham Hospital rather than 219. Also, we confirmed that the admission and discharge date was correct for an additional 43 rather than the 48 who according to the HCFA list died subsequent to hospitalization. We could not verify that these 43 patients actually did die post-hospitalization as information concerning death after discharge is not included in the patient's medical record.

Errors found in the HCFA data are listed on the attached reports. It should be noted that one death listed by HCFA could not be verified as having ever been a patient at Chippenham Hospital.

HOSPITAL COMMENTS FOR PUBLICATION

Chippenham Hospital fell well within the mortality rate norms for all diagnostic categories established by HCFA. However, it should be noted that this data does not

The hos "s comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the al. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

provide allowances for those hospitals that offer complex services. Chippenham Hospital is a full service facility that treats many complicated and complex cases which may result in higher than the average mortality rate. To properly interpret mortality data there must be a full case mix analysis. At Chippenham Hospital we are and will continue to be committed to the delivery of high quality patient care.

Should there be any questions concerning the attached corrections or comments above, please feel free to contact me.

Sincerely,

Richard C. Kraus
Administrator

RCK/bcg

enclosures

CHIPPENHAM HOSPITAL
RICHMOND, VIRGINIA

ERRORS IN HCFA MORTALITY DATA

PATIENT ID NUMBER (HIC)	SURNAME (FIRST 6 LTRS)	ERROR
[redacted]		Date of death listed as 2/26/86; correct date is 2/25/86
[redacted]		Sex listed as F; M is correct sex
[redacted]		Date of death listed as 1/31/86 correct date is 1/27/86
[redacted]		Date of death listed as 6/16/86; correct date is 6/15/86
[redacted]		Date of death listed as 9/16/86; correct date is 9/7/86
[redacted]		Date of death listed as 6/30/86; correct date is 6/29/86
[redacted]		No principal procedure code listed; principal procedure was 37.61
[redacted]		Date of death listed as 2/21/86; correct date is 2/12/86
[redacted]		Age listed as 78; correct age is 81
[redacted]		Age listed as 68; correct age is 71
[redacted]		Age listed as 77; correct age is 75
[redacted]		No record of this patient ever being hospitalized at Chippenham Hospital
[redacted]		Date of death listed as 4/15/86; correct date is 4/16/86
[redacted]		Date of death listed as 7/9/86; correct date is not known, patient was discharged alive on 7/18/86
[redacted]		Age listed as 82; correct age is 81

CHIPPENHAM HOSPITAL
RICHMOND, VIRGINIA

ERRORS IN HCFA MORTALITY DATA

PATIENT ID NUMBER (HIC)	SURNAME (FIRST 6 LTRS)	ERROR
[redacted]		Age listed as 81; correct age is 78
[redacted]		Age listed as 92; correct age is 98
[redacted]		Age listed as 79; correct age is 76

COMMUNITY HOSPITAL OF ROANOKE VALLEY

W. R. REID
PRESIDENT

October 28, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, DC 20201

Dear Doctor Roper:

The hospital's Medical Record Department has verified as closely as could be ascertained the comparison of the mortality information planned to be published by the Healthcare Financing Administration with hospital records.

The following errors are noted.

1. HCFA had patient [redacted] listed as expiring on the date of discharge form the hospital but we find no patient with that identification registered. It appears to be a duplication of BEEM who has same HIC number, same age and same dates of hospitalization.

2. Codes listed wrong on ICD-9-CM code sheet:

   CA - 174-209, should be 174-208
   GC - 572.7 should be 572.4
   TR - 946.9 should be 946.5
   GU - 609 should be 608

Thank you for the opportunity to review this information prior to publication.

Sincerely,

Thomas S. McCallie,
Executive Vice President

ka

VHA Partner–VHA Mid-Atlantic Affiliate of the Voluntary Hospitals of America System.

P. O. BOX 12946 • ROANOKE, VIRGINIA 24029 • (703) 985-8000
VA 22

Comments on the HCFA Mortality Data
DePaul Hospital, Norfolk, VA
October 26th, 1987

The HCFA Mortality Data has been reviewed and verification and evaluation of that data has begun. The statistics will serve as a component of the hospital's ongoing quality management process. As one of the many internal monitors the hospital uses to flag charts for the more detailed and specific peer review process, the HCFA data serves as a second check to the process. It is important to point out that our mortality rate, as with any of the other hospital specific rates utilized, serves only as a flag for review of the actual care given, and not an indication of quality or disquality. The Joint Commission, The American Hospital Association, other professional organizations, hospitals and hospital systems as well as HCFA, are invested in continued research, trying to identify ways to give the public better assurance of the quality of care provided in health care facilities today. We can expect to see the methodology change as we develop better yardsticks to measure the quality of care we render, taking into consideration such important factors as severity of illness and other qualifying factors in the evaluation of that care. In our present quality management program, we review all inhouse records for a number of unexpected outcomes, one of which is death. Any records in that category in which there is any question goes on for physician review. Concerns, questions or breeches of the standard of care would go on to the department for final review and would be reported back to the Medical Quality Assurance Committee. All the charts within the HCFA data were included within that process.

Verification Data/HCFA Mortality Statistics/1986

The HCFA data indicates that a total of 2,518 medicare patients were seen. Our records demonstrate a total medicare population of 4,173 patients for 1986. It is presumed that this discrepancy reflects multiple admissions of our medicare population which is not reflected in the HCFA data. The HCFA statistics reflect only the last admission for the year in the total. The HCFA data indicates that a total of 281 medicare patients died within 30 days of admission, 227 while still in the hospital and 54 post discharge. Our records indicate that 2 of the 54 patients that HCFA reported as dying post discharge proved erroneous. One of those two patients was transferred to another acute care facility out-of-state, a second was a duplicate of another record. In addition, one patient who was included as an inpatient death, had a 1987 admission to this hospital. A second patient included in the inpatient deaths was discharged home and his present status has not been verified.

Interpretation of HCFA Data

The hospital's actual mortality rate did not fall outside the range of the predicted rates in any of the categories. An evaluation of the seventeen categories of data was initiated. The following comments seem applicable to that general review.

Category I HS/Severe Acute Heart Disease

In this category, 29 deaths out of the 39 total were in DRG 410 or Acute Myocardial Infarction. An Acute Myocardial Infarction, representing the

true "heart attack", comes with a higher risk than many of the other DRG's in the category. Because the model does not take into account either the severity of the condition or the history of previous MI's, the data could tend to be skewed with 74% of the deaths falling into this category. In addition, twelve of those cases or 41% had accompanying cardiogenic shock representing a major complication and greatly increasing the associated morbidity. It is impossible to evaluate whether this co-morbid condition was included in the model since we do not have access to the billing data utilized by HCFA. Of that category, 29 of the total of 39 patients in the Category of HS/Severe Acute Heart Disease, were admitted through our Emergency Department and 9 of those 29 arrived via our Paramedical Rescue Service, 7 of which had arrested in the field further increasing the mortality rate.

Category II/GC/Gastrointestinal Catastrophe

Six of the ten cases were from DRG 560, Intestinal Obstruction, carrying a high mortality rate. Additional disease processes also complicated the picture in this category. A patient suffering from multiple disease processes is much more difficult to treat. As you improve one body system, another one dysfunctions. A case listing demonstrating the above will follow.

Case #1: Cancer of the endometrium, ascites, pleural effusion.

Case #2: Patient died of MI, complicated by cardiovascular disease, diabetes, heart failure.

Case #3: Quadriplegic, pneumonia, cancer of colon that had spread to lungs.

Case #4: Transferred to an acute care facility in North Carolina.

Case #5: Liver disease with ascites, peripheral vascular disease, terminal kidney failure, diabetes.

Case #6: Arteriosclerotic heart disease and heart failure, atrial fibrillation. Not a surgical candidate due to advanced heart disease.

Case #7: Heart failure, lung disease, obesity, non-Hodkin's lymphoma, diabetes.

Case #8: Kidney failure, atrial fibrillation and flutter.

Case #9: Recurrent small bowel obstruction, had acute MI.

Case #10: Stroke, peripheral vascular disease, heart failure, liver disease, diabetes.

Case #11: Liver disease, kidney failure, peptic ulcer disease. Patient had Vibrio vulnificus, an infection that is contracted from eating raw seafood. When in the presence of liver disease, it carries a 50% mortality.

SMC/HMH/jrm

	Deaths Reported by HCFA		Deaths Verified by Hospital	
Diagnostic Category	In-hospital	Post-hospital	In-hospital	Post-hospital #
CA -- Cancer	36	9	36	-
CE -- Cerebrovascular Accidents	22	3	22	-
GC -- Gastrointestinal Catastrophes	10	2 *	10	1
GI -- Gastrointestinal Desease	10	2	10	2
GU -- Urologic Disease	3	1 ***	3	-
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	4	2	4	-
HM -- Severe Chronic Heart Disease	17	3	16	-
HS -- Severe Acute Heart Disease	36	3	36	-
ME -- Metabolic/Electrolyte Disturbances	4	7 **	3	-
OP -- Orthopedic Disorders	1	0	1	-
PN -- Pulmonary Disease	31	2	30	-
RN -- Renal Disease	2	0	2	-
SE -- Sepsis	1	1	1	-
TR -- Severe Trauma	9	0	9	-
EY -- Ophthalmalogic Disease	1	0	1	-
UN -- Other Diagnoses	40	19	37	-

*** Numbers stay same, but 1 pt. listed as dying in-house that went home, and a 2nd one died in house that was not listed as an in-house death.

* 1 pt. transferred out - to North Carolina Acute care facility

** duplicate cases

in process of confirming

COMMONWEALTH of VIRGINIA

EASTERN STATE HOSPITAL
Telephone: (804) 253-5161

Department of
MENTAL HEALTH AND MENTAL RETARDATION

Drawer A
Williamsburg, Virginia 23187

October 6, 1987

William L. Roper, M. D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Re: Provider #490109

Dear Mr. Roper:

Thank you for your letter of September 21, 1987, giving Eastern State Hospital an opportunity to comment on the Medicare mortality statistics before they are published in December, 1987.

We would like to comment as follows:

Date of Admission: We have 421 geriatric beds (which includes 25 SNF beds). When patients become acutely ill, they are transferred from the ICF unit to the Medical Services unit for more intensive medical treatment. Medicare reimburses the hospital for patients in the Medical Services unit by DRGs. The list attached to your letter of September 21, indicates the transfer date from the ICF unit to the Medical Services Unit as the admission date.

The actual admission dates have been typed on the attached list. If the actual admission date to Eastern State Hospital cannot be corrected in the report to be published in December, 1987, kindly print the following note to our statistics.

NOTE: Eastern State Hospital, Williamsburg, Virginia, has 421 psychiatric geriatric (ICF) beds. When patients become acutely ill, they are transferred from the ICF unit to the Medical Services unit for more intensive medical treatment.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data

Medicare reimburses the hospital for services in the Medical Services Unit by DRGs. The admission date listed is actually the transfer date from ICF unit to the Medical Services unit. Therefore, the average LOS of the 15 Medicare patients who died in 1986 using the actual date of admission to the ICF unit and date of death is 1,762 days (4 yrs. 10 mos).

With reference to patient [redacted] our records indicate that this was not an Eastern State Hospital patient.

If you have any questions, please contact me at (804) 253-5241.

Very truly yours,

David C. Pribble
Hospital Director

LG/rlt
cc: Jennifer Fidura
Deputy Commissioner
DMHMRSAS

FAIR OAKS HOSPITAL
FAIRFAX HOSPITAL SYSTEM

Fair Oaks Hospital
3600 Joseph Siewick Drive
Fairfax, Virginia 22033
703 391-3600

Steven E. Brown
Vice President, Fairfax Hospital System
Administrator, Fair Oaks Hospital

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
6300 Security Boulevard
Meadows East Building, 2-D-2
Baltimore, Maryland 21207

Dear Doctor Roper:

On behalf of Fair Oaks Hospital, we commend HCFA for taking on the challenge of issuing mortality data for the nation's hospitals. We support this effort, which helps us fulfill our mission of providing top quality care, and which can provide useful information to the people in this community.

It is gratifying to learn that *all* of the mortality rates for Fair Oaks Hospital fall within the ranges predicted by HCFA's statistical model. This reflects our unyielding commitment to quality medical care for all our patients.

Despite your good efforts -- and the support of many in the health care field -- it must also be realized that the data on hospital mortality rates released by HCFA must be interpreted very carefully.

Even though the current HCFA statistical model has been improved, it is new and untested. The model does provide accurate and reliable estimates between the five patient characteristics -- patient age, sex, prior hospitalizations, transfer from another facility, and other illnesses -- and the risk of death. It is not known, however, whether these five factors are the most significant ones. Finally, there is considerable reason to believe that the model does not adequately take into account severity of illness. Because of these and other limitations, it is important to understand how to interpret the data from each individual hospital.

Thank you for the opportunity to comment on these data. Again, we applaud your efforts and support your continuing quality of care information initiative.

Sincerely,

Steven E. Brown
Vice President, Fairfax Hospital System
Administrator, Fair Oaks Hospital

Sincerely,

William C. Dempsey, M.D.
President, Medical Staff
Fair Oaks Hospital

/csw
Attachment

FAIR OAKS HOSPITAL

HCFA MORTALITY DATA COMMENTS

I. INTRODUCTION

- As a provider of quality medical care, Fair Oaks Hospital, an affiliate of Fairfax Hospital System, supports responsible efforts to make available useful information describing health care providers. The Health Care Financing Administration (HCFA) is "critically aware that to be useful a public information release must be understandable and convenient to use."

- Fair Oaks Hospital is pleased that its actual mortality rates are within HCFA's predicted range in every diagnosis category. In its continuing efforts to look for ways to enhance the quality of care for all its patients, Fair Oaks Hospital is committed to quality medical care.

- HCFA openly acknowledges that there are limitations in the data and the statistical model. The American Hospital Association states that the "reliability of the (HCFA) model is unknown but appears to be quite limited." It also reports that the HCFA model "has not been validated." While the data for Fair Oaks Hospital shows that the actual mortality rates are within the model's acceptable range of predicted mortality rates in every instance, several points should be identified to support responsible use of the information.

II. DATA VERIFICATION

- Based on data from the Medical Society of Virginia Review Organization (MSVRO), HCFA's quality review organization for Virginia, the HCFA data may be inaccurate and overstate the actual mortality rate for Fair Oaks Hospital.

    - Of the 864 patients HCFA identifies, HCFA shows 82 died in the Hospital.

    - The MSVRO reports 960 patients, and that only 76 died while in the hospital.

    - The HCFA mortality rate for these patients is 9.5%, while the MSVRO data describes a rate of only 7.9%.

III. DATA INTERPRETATION

- One significant limitation of the model is that it does not account for severity-of-illness. In other words, two patients with the same diagnosis can have significantly different levels of illness severity. Research by national experts strongly suggests that severity-of-illness, in addition to diagnosis and demographic information, is a significant factor in predicting mortality rates. The importance of incorporating severity-of-illness in predicting mortality rates is further evidenced by the U.S. Congress ordering of the Department of Health and Human Services to complete a severity-of-illness study by October 1988 to determine whether Medicare payments to hospitals should be adjusted.

- The Medicare patients who died at the Hospital were severely ill at the time of their admission. Considering the total number of Medicare patients who died, 77% were emergency patients and another 22% were urgently admitted to the Hospital. Thus, over 99% of the total number of patients were either emergent or urgent admissions. These patients were obviously severely ill at the time they initially came to the hospital.

    - In the category Severe Acute Heart Disease, for example, 100% of the Medicare patients who died were emergency patients. Moreover, 95% of these patients had acute myocardial infarctions, more commonly known as heart attacks; additionally, many of these patients also had a host of other severe acute heart conditions including cardiac arrest.

- The HCFA model does not explicitly recognize the cause of death. One-fourth of the reported Medicare patient deaths for Fair Oaks Hospital occurred after the patient was released from the Hospital (The HCFA model includes all Medicare patients who died within 30 days of hospital admission.). The cause of death for these people is therefore not known with certainty to be related to the reasons they were admitted to the Hospital.

- Finally, the data reported is based on the 1986 experiences of Medicare patients at Commonwealth Hospital, not Fair Oaks Hospital. Fair Oaks Hospital opened in June, 1987.

IV. SUMMARY

- Fair Oaks Hospital routinely analyzes the quality of care provided for all patients, including physician review of all deaths. The Hospital took the opportunity presented by the HCFA information disclosure to further analyze the medical records of the Medicare patients who died. This investigation found no evidence of any systematic reasons for the deaths of these patients other than their being severely ill at the time of their admission to the Hospital.

- The actual mortality rates for Fair Oaks Hospital are within HCFA's predicted range in every category. This reflects our continuing efforts to provide high quality care for all the patients at Fair Oaks Hospital.

FAIRFAX HOSPITAL SYSTEM
A DIVISION OF INOVA HEALTH SYSTEMS

8001 Braddock Road
Springfield, Virginia 22151
703 321-4213

C. Michael French
President

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Baltimore, Maryland 21207

Dear Dr. Roper:

As President of Fairfax Hospital System, and Chairman of the FHS Medical Affairs Council, we want to commend you and your staff for taking on the challenge of issuing mortality data for the nation's hospitals. This initiative complements and supports our efforts to provide quality care for all of our patients.

It is gratifying to learn that mortality rates at each of Fairfax Hospital System's four hospitals fall into the ranges predicted by HCFA's statistical model. This holds true for aggregate rates and for each of the sixteen diagnostic categories as well.

It should also be noted that, although HCFA's data on hospital mortality rates do not measure quality of care, they can be a useful part of our comprehensive quality assurance program.

The current HCFA statistical model is not without its drawbacks. It is new and untested. It does not include measures of severity, so it does not consider how ill patients were upon admission. The model counts patients only once, even if they were admitted several times during 1986. Therefore it can artificially inflate the mortality rate per admission for all hospitals.

Due to these limitations, it is important to understand the appropriate context in which to interpret the data from each of our individual hospitals. The attached hospital responses address that challenge.

Thank you for the opportunity to comment on these data.

Sincerely yours,

C. Michael French
President and
Chief Executive Officer

Ira S. Young, M.D.
Chairman,
Medical Affairs Council

FAIRFAX HOSPITAL
FAIRFAX HOSPITAL SYSTEM

Hospital I.D. #490063

Fairfax Hospital
3300 Gallows Road
Falls Church, Virginia 22046
703 698-1110

Everett M. Devaney
Vice President, Fairfax Hospital System
Administrator, Fairfax Hospital

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
6300 Security Boulevard
Meadows East Building, Room 2002
Baltimore, Maryland 21207

Dear Dr. Roper:

On behalf of Fairfax Hospital, an affiliate of the Fairfax Hospital System, we thank you for the opportunity to provide comments to help the public interpret our mortality statistics. These comments are essential to understanding the data since statistical methods for predicting mortality alone are not yet sophisticated enough to be valid and reliable indicators of quality. HCFA's efforts are a move in the right direction and we support them.

The hospital has an active quality assurance program which collects and analyzes patient care data on a daily basis. All deaths are routinely reviewed for appropriateness of care as part of this program. The HCFA statistics provide an additonal opportunity to review our performance.

Your study results support that our efforts to monitor and improve the care we deliver have a beneficial effect. Mortality rates for the hospital are well within the ranges of HCFA's predicted mortality for each of the 16 diagnostic categories and overall.

Again, thank you for this opportunity for input. We look forward to working with you in future years as the predictive methodologies and data improves.

Sincerely,

Everett M. Devaney
Vice President/Administrator
Fairfax Hospital

EMD:cml

Hospital I.D. #490063

FAIRFAX HOSPITAL
HCFA MORTALITY DATA COMMENTS

I. INTRODUCTORY COMMENTS

Thank you for the opportunity to comment on the mortality statistics for 1986. Fairfax Hospital supports efforts to inform the public about health care and H.C.F.A.'s study has made a good effort in that regard.

The following information is provided to assist in interpreting the mortality statisics for Fairfax Hospital:

- Fairfax Hospital is a 656 bed full service hospital. The hospital offers all general medical and surgical services but also offers high level specialty care in oncology, trauma care, obstetrics, open-heart surgery and heart transplants. Because we are a tertiary referral and teaching center for these programs a larger portion of our patients are more severly ill than patients typically found in general community hospitals. Other measures of the level of severity, such as the Medicus Acuity System, support that Fairfax Hospital's patients are more critically ill than the average hospital patient mix in most clinical areas.

- Fairfax Hospital and the medical staff routinely review the records of all patients who die in the hospital. This review is part of our ongoing Quality Management Program. This review provides continuous information on the appropriateness of care delivered at the hospital and allows corrective actions to be taken if necessary.

II. DATA VERIFICATION

- Since deaths which occurred outside the hospital could not be verified, and because the study does not include all Medicare patients treated, we were not able to validate data accuracy with 100 percent assurance the total number of records used in each diagnostic category. Hospital records for example include 149 relevant cases in the acute severe cardiac disease area. HCFA's data included only 102 cases in this category. This discrepancy would impact calculation of mortality rates.

III. DIAGNOSTIC CATEGORY SPECIFIC INFORMATION

- Fairfax Hospital's mortality rates are well within the range of predicted mortality in all 16 diagnostic groups and for the hospital overall.

- The hospital and members of the medical staff reviewed records for all deaths in six of the diagnostic categories where the number of cases were large enough to be significant and where the hospital is a major referral center. The results of that review follow.

Cancer (CA)

- The actual mortality rate was 22%, well within the range of 16% to 31% of predicted mortality. There were 62 deaths reported.
- Fairfax Hospital has the largest cancer program in the Washington, D.C. metropolitan area.
- Cancer patients are typically seriously ill and experience multiple admissions.
- Of the 62 cancer deaths reported, there were 20 readmissions.
- 88% of the patients who died were admitted through the emergency department for their final admission.
- 24% of the patients died after discharge to a hospice, nursing home or home with home health care services. Review of these cases indicated these discharges to be appropriate.
- The average age of patients who died was 73 years.

Cardiac Care

- Three diagnostic categories were reviewed including low-risk heart disease (HL), severe chronic heart disease (HM), and acute severe heart disease (HS). Actual mortality in these categories was within the range of predicted mortality as indicated below:

	Acutual Mortality	Predicted Mortality
Low Risk	5%	2% - 7%
Severe Chronic	21%	16% - 31%
Acute Severe	40%	29% - 49%

- Fairfax Hospital is a tertiary care, cardiac referral center offering general cardiac care, open heart surgery and heart transplantation.
- 29% of patients who died in the low risk category, 10% in the acute severe group and 8% of severe chronic cardiac cases were transfered to Fairfax Hospital from other hospitals for specialized treatments including open heart surgery and percutaneous transluminal cardiac angioplasty.
- In the acute severe category, 87% of patients who died were admitted from the emergency department with a heart attack or aortic aneurysm.
- In the acute severe category over a third had complicating secondary conditions including pneumonia, renal failure, hypertension, diabetes and cancer.
- The average age of patients who died in the acute severe category was 77 years.

Pulmonary Disease (PN)

- Actual mortality of 24% was within the predicted range of 14% to 28%. There were 45 deaths reported.
- Pulmonary patients experienced 17 readmissions for treatment of their chronic pulmonary conditions.
- Over 84% of the patients who died were admitted through the emergency department.
- 8 patients required resusitation while in the hospital.
- Pulmonary patients had underlying diseases complicating treatment of the pulmonary problems. Other conditions included pneumonia, congestive heart failure and kidney failure.
- The average age of patients who died was 75.5 years.

Franklin Memorial Hospital

124 Floyd Avenue
Rocky Mount, Virginia 24151
(703) 483-5277

RAYBURN A. THOMPSON, JR.
Administrator

October 6, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The Quality Assurance Committee of Franklin Memorial Hospital has reviewed the mortality information received from you on September 21, 1987 and would like to state that we do not feel these numbers are indicative of quality care and would be of no useful benefit to any physician or patient.

We are concerned about the quality of health care in our nation but do not feel this kind of information contributes to quality care.

Yours truly,

Christine Barrett M.D.

Christine Barrett, M.D.
Chairperson, Quality Assurance Committee

CB/gs

GILL MEMORIAL EYE, EAR, NOSE AND THROAT HOSPITAL, INC.

711 JEFFERSON STREET S.W. • P. O. BOX 1789 • ROANOKE, VIRGINIA 24008 • 344-2071

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

I have reviewed the Hospital mortality information for 1986 and have found the information to be misleading. The primary question this project was to answer "what is the actual death rate for each hospital compared to what would have been expected for that particular hospital given the characteristics of patients admitted?" has not been accurately answered in the case of this hospital.

The one individual reported as a mortality for this hospital, a 93-year-old female with multiple physiological problems, was assigned to this facility because this was her last admission to a hospital prior to her death in 1986. This female was admitted to the Hospital for ambulatory surgery and received a cataract extraction with an intraocular lens implant. The female patient was seen by her surgeon on two postoperative office visits during the two weeks following her surgery and the eye procedure was determined to have been successful and without complication.

Without disturbing this female's family, a determination could not be made as to the reason or location of her death during December, 1986. However, as the Hospital and physician records illustrate, her ambulatory surgery cataract extraction did not result in her death.

The Health Care Financing Administration's objective of establishing and publishing measures of quality of care in hospitals can provide the public with valuable information. However, the current methodology of sorting Medicare beneficiary data in an effort to assign a mortality rate to individual hospitals provides the public with very misleading information and does not address issues that determine the quality of care provided in hospitals.

The Joint Commission on Accreditation of Healthcare Organizations has developed and is developing excellent indicators of quality of care. The JCAHO quality of care indicators should be considered for use by HCFA instead of this misleading data currently being generated.

Thank you for the opportunity to comment on this matter.

Sincerely,

Donald J. Love
Administrator

jjs

Halifax-South Boston Community Hospital

ACUTE CARE DIVISION

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

RE: HCFA Mortality Data
Medicare Provider No. 49-0013

Dear Sir:

Halifax-South Boston Community Hospital has reviewed the mortality data prepared by your office concerning Medicare patients treated at our Hospital in 1986. We have found your statistical information correct with the exception of a relatively small number of death dates which, however, still fell within the 30-day admission date time frame.

Our highest actual mortality rates were in the diagnostic areas of cancer and cerebrovascular accidents. Although these figures are well within the predicted national mortality rates, we would like to address these two diagnostic areas.

According to our records, breast cancer and cancer of the major organs account for two of the top ten DRG statistics at our facility. Nationwide studies show that terminally ill cancer patients prefer familiar surroundings during the last stages of their illnesses, as opposed to treatment at a large medical center.

In reference to cerebrovascular accidents, it should be noted that the service area of our hospital has a 40 percent non-white population compared to 17 percent non-white nationally according to the 1980 U.S. Census Bureau. National medical findings that hypertension, which leads to cerebrovascular accidents, is more common to the non-white population, explaining the high incidence of cerebrovascular accidents.

We appreciate being given the opportunity to respond to HCFA's Mortality Data report and plan to use this information in planning future health care services for our community.

Sincerely,

Terence F. Bennett
Administrator

TFB:skc

2204 ILBORN AVENUE ✣ SOUTH BOSTON, VA. 24592 ✣ (804) 575-7961

Hampton General Hospital

Hospital ID Number 490093

COMMENTS ON THE 1986 HCFA MORTALITY DATA

DATA VERIFICATION

The data used by HCFA indicate that a total of 267 Medicare beneficiaries admitted to Hampton General Hospital during 1986 died within 30 days of admission. Of these, HCFA indicates that 237 beneficiaries died in the hospital while 30 died after discharge.

Our own records of these Medicare beneficiaries indicate that 240 people died while inpatients at Hampton General. The remaining 27 beneficiaries who HCFA indicates died within 30 days were discharged alive from Hampton General. It is impossible to verify the deaths of all of these patients since the Hampton General medical record includes information only for the time patients remained in the hospital.

It is important to note, however, that 4 Medicare beneficiaries discharged alive were transferred to the Kecoughtan Veterans Administration Medical Center. An additional 4 beneficiaries who were discharged alive were transferred to extended care facilities. We have no way of verifying that other patients who were discharged alive were not admitted subsequently to another acute care institution.

One Medicare beneficiary whom HCFA indicated died from sepsis was ruled upon autopsy to have died from severe chronic heart disease.

INTERPRETATIVE REMARKS

In each of the diagnostic categories, Hampton General's actual mortality rate falls within the range of predicted mortality rates.

After correcting for the coding error affecting the sepsis category and the severe chronic heart disease category, the actual mortality rate would be 38% and 21% for these categories respectively.

After correcting for the three cancer patients who were transferred alive to the Veterans Administration Medical Center, the actual mortality rate for the Cancer category would be 28%.

ictoria Boul • Hampton, Virginia 23669-0640 • (804) 727-7000

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

After correcting for the metabolic/electrolyte disturbance patient who was transferred alive to the Veterans Administration Medical Center, the actual mortality rate for the metabolic/electrolyte disturbance category would be 12%.

Hampton General is pleased that our actual mortality rates are considered normal by HCFA. We would caution anyone from using these rates in comparing Hampton General with other institutions. There is a considerable array of medical and social factors which need to be evaluated before a death can be considered "appropriate." Mortality rates can serve only as sentinels for potential chart review. It is only by a thorough review of a patient's medical record that conclusions may be drawn regarding the appropriateness of medical care provided prior to the patient's death.

RESULTS OF PRELIMINARY MEDICARE RECORD REVIEW

Hampton General's Quality Assurance Department, staffed by a trained administrator and a registered nurse fully familiar with medical records procedures, has conducted a preliminary review of the cases included in HCFA's mortality database.

All cases resulting in death post hospital and all trauma and renal deaths were reviewed. Of the cases examined, three will be sent to the Medical Staff's Quality Care Committee for further examination by physicians to determine the appropriateness of the care given. If any corrective action is warranted after this peer review, the Quality Care Committee and the Quality Assurance Department are in place to implement the necessary actions.

QUALITY ASSURANCE ACTIVITIES AT HAMPTON GENERAL

The Quality Assurance Department and the Quality Care Committee of the Medical Staff mentioned above, serve to coordinate and integrate the activities of Hampton General Hospital's Quality Assurance Program. The program includes retrospective and prospective evaluations, as well as systematic ongoing monitoring and evaluation of important aspects of patient care designed to provide the opportunity to improve patient care and to ensure resolution of identified problems. All departments and committees of the Hospital and the Medical Staff responsible for the provision and continuity of patient care are involved.

Hampton General Hospital

Hospital ID Number 490093

ANNUAL MORTALITY REVIEW

Mortality review is only one aspect of any hospital's approach to improving quality. Again, it is important to remember that the incidence of mortality alone is not an indicator of quality. Mortality rates can serve only as sentinels pointing to the need for further review by medically trained peers.

At Hampton General Hospital, the mortality rates of all (not just Medicare) patients for all physicians in all specialties are reviewed annually. Detailed information is gather by the Quality Assurance registered nurse and presented to the Quality Care Committee. It is then reviewed by each Medical Staff department. Wherever necessary more detailed peer review of medical records is conducted and corrective action is taken.

RELEASE OF MORTALITY DATA

Hampton General Hospital believes strongly that Quality Assurance activities are a necessity for all hospitals. It takes seriously the efforts of its own Quality Assurance Program and continually strives to improve quality whenever opportunities for improvement arise. Hampton General participates in the program of the Joint Commission on Accreditation of Hospitals and supports its Quality Assurance efforts.

Hampton General Hospital, however, disagrees with HCFA's view that release of Medicare mortality data serves a useful purpose. Review of mortality data is useful only when accompanied by detailed examination of medical records by medically trained peers. To draw conclusions regarding hospitals' comparative quality based on mortality rates alone, is to ignore the underlying medical and social factors which the appropriateness of the medical care an individual might have received. We believe that HCFA's release of mortality data encourages superficial comparisons of hospitals. These superficial comparisons are unfair and in all likelihood lead to erroneous conclusions.

We share HCFA's concern over the quality of care Medicare beneficiaries receive. If HCFA feels that it must develop comparative indices of hospital quality, we call on it to develop a more comprehensive measure than the flawed method of mortality rates.

3120 Victoria Boulevard • Hampton, Virginia 23669-0640 • (804) 727-7000

Hampton General Hospital

Hospital ID Number 490093

Attachment 1

ANALYSIS OF REPORTING ERRORS

DIAGNOSTIC CATEGORY	DEATHS REPORTED BY HCFA		DEATHS VERIFIED BY HGH	
	IN-HOUSE	POST HOSPITAL	IN-HOSPITAL	POST HOSPITAL
CA	37	8	38	7
CE	28	3	29	2
GC	6	0	6	0
GI	10	3	11	2
GU	3	0	3	0
GY	1	0	0	1
HL	6	2	6	2
HM	21	1	22	1
HS	21	0	21	0
ME	9	3	8	4
OP	3	1	3	1
PN	31	4	31	4
RN	7	0	7	0
SE	9	0	8	0
TR	8	1	9	0
OP	0	0	0	0
UN	37	4	38	3
Total	237	30	240	27

FORM 229

COMMONWEALTH of VIRGINIA

Department of
Mental Health and Mental Retardation

LOUIS E. DOUCET
DIRECTOR

HIRAM W. DAVIS MEDICAL CENTER
P. O. BOX 4030
PETERSBURG, VIRGINIA 23803

October 14, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

SUBJ: HCFA Mortality Report, 1986
Hiram W. Davis Medical Center
Provider No. 49-0104

Gentlemen:

This is in response to Dr. William L. Roper's communication of September 21, 1987. We have reviewed the above referenced mortality report and submit the following comments:

1. The name of the hospital should be corrected from Hiriam Davis Memorial Hospital to Hiram Davis Medical Center.

2. Our records indicate the age of Patient ID Number [redacted] to be 78 years.

3. Our records indicate the age of Patient ID Number [redacted] to be 96 years.

Thank you for the opportunity to comment.

Yours truly,

Silas Burnette, Jr.
Silas Burnette, Jr.
Interim Director

SBjr/jgw

cc: Dr. Clemente Estrera
Mrs. Nancy Lewis

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

800 Independence Blvd.
P.O. Box 5695
Virginia Beach, Virginia
23455-6076
Telephone 804 460-8000

Humana Hospital
Bayside

October 26, 1987

William L. Roper, M.D.
Administrator, Health Care
Financing Administration
Department of Health and Humana Services
Attention: HSQ-148-GNC
P.O. Box 26676
Baltimore, Maryland 21201

Dear Mr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Bayside supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

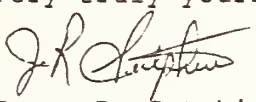
Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our Hospital's Medical Records staff has reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Very truly yours,



Jerry R. Sutphin
Executive Director

JRS:glh

7700 Parham Road
Richmond, Virginia
23229
Telephone 804 747-5600

Humana Hospital
St. Lukes

October 23, 1987

Dr. William Roper
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital-St. Lukes supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's Medical Records and Quality Assurance Departments have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Gnerally, we have found it to be consistent with some exceptions with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

I hope this response will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Nancy R. Hofheimer

Nancy R. Hofheimer
Executive Director

NRH/mw

2949 West Front Street
Richlands Virginia
24641
Telephone 703 963-0811

Humana Hospital
Clinch Valley

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital-Clinch Valley supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admisssions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they must assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's medical records, quality assurance and medical staff have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards".

Specifically, we reviewed all categories and find that under category ME (Metabolic/Electrolyte Disturbances) that several factors existed to make this category very suspect regarding reliability. These are: The number of patients (5) is too small to be statistically meaningful. The average age of the category was 81. Finally, two of the five were "NO CODE" patients requested by their respective families so the death was not preventable.

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Respectfully,

W. A. Gillespie

W. A. Gillespie
Executive Director

WAG/ksh

JEFFERSON HOSPITAL
FAIRFAX HOSPITAL SYSTEM

Jefferson Hospital
4600 King Street
Alexandria, Virginia 22302
703 931-9700

Richard A. Levy, Jr.
Vice President, Fairfax Hospital System
Administrator, Jefferson Hospital

October 28, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
6300 Security Blvd., Suite 2-D-2
Baltimore, MD 21207

RE: 1987 HCFA Mortality Data
Jefferson Hospital
Alexandria, VA 22302
#490008

Dear Dr. Roper:

Enclosed please find the response by Jefferson Hospital for inclusion in the December, 1987 report by HCFA on Medicare mortality data.

We are pleased to have the opportunity to review and comment upon the material. Your effort to provide consumer information to the general public about health care issues is certainly well intentioned.

However, the HCFA statistical model has several shortcomings, which can seriously affect the reliability of the predictions. For example, the HCFA methodology allows for the impact of certain factors (e.g. age, sex, co-morbidity etc.) on expected patient outcome, but it does not adequately account for the severity of illness.

Jefferson Hospital proudly notes that its mortality rates fall within or below the ranges predicted by the HCFA model. More importantly, clinical review of patient records confirm the appropriateness of the care rendered.

As a member of the Fairfax Hospital System, Jefferson Hospital will continue its cooperative efforts with HCFA to inform the American public about important health care issues.

Sincerely,

Richard A. Levy, Jr.

RICHARD A. LEVY, JR.
Administrator

MICHAEL E. DAVIDOV, M.D.
Medical Staff President

RAL:tc

Enclosure

JEFFERSON HOSPITAL
ALEXANDRIA, VA 22302
#490008

Comments on 1986 HCFA Medicare Mortality Data

Introduction

Jefferson Hospital is pleased to submit its comments on the HCFA Medicare mortality data for this institution. We believe that information of this sort can be helpful to the general public, if it is placed in the proper context. We wish to note that the HCFA statistical model for developing this information has several major limitations, as described in testimony given by the various health care industry sources. The public should realize that there is no methodology available now which can accurately reflect the complex factors affecting the outcome of patient treatment. Only a careful review of the medical record by qualified professionals can provide a true basis for judging the quality of care rendered by a hospital.

Data Verification

According to HCFA, there were 515 Medicare admissions to Jefferson Hospital in 1986; of these, 35 patients expired. Hospital data indicate that this case sample may be incomplete; but resolution of this discrepancy is not possible, given the limits of the HCFA data provided.

Of the 515 admissions listed by HCFA, 35 patients died either in the hospital within 30 days of admission or 30 days after discharge in 1986. These data are essentially correct. However, it should be noted that one patient listed as having expired after discharge in late 1986 was actually readmitted in early 1987 and died while hospitalized.

Interpretive Remarks

According to the HCFA statistical model, 7% - 15% of the 515 patients admitted would be expected to expire. In fact, the 35 listed patients who died represent 6.8% of Medicare admissions at Jefferson Hospital. Thus, the Jefferson Hospital mortality statistic falls below the range predicted by the HCFA model.

HCFA divides all mortalities into 17 classifications; 10 of these are considered high risk categories. 31 of the 35 listed mortalities at Jefferson Hospital fell into the high risk category. Of the remaining 4 (all of which were Gastrointestinal Disease: GI classification), clinical review of the charts indicate that death was a significant possibility, given the chronic and co-morbid conditions of the patients.

The two classifications containing the largest number of the 31 remaining mortalities were Cancer: CA (10) and Severe Chronic Heart Disease: HM (6). These two categories account for 52% of the deaths reported in the severe disease categories. The average age of these 31 patients at the time of death was 74.4 years. The average length of stay for the 31 patients was 10 days. However, 13 patients died within 5 days of admission (42%).

Specific chart reviews were conducted on a series of cases, because several attending physicians had 3 or more patients who expired. In each case, death was considered to be either expected or probable because of the severity of the primary disease and/or the existence of other co-morbid conditions.

Summation

In summary, Jefferson Hospital mortality statistics fall within the ranges predicted by the HCFA model for all 17 disease classifications. More significantly, a detailed analysis of patient charts shows that medical management of the patients who expired was appropriate. The HCFA mortality data should therefore be used only as indicators for further study and evaluation of selected medical records. There is no statistical model which can substitute for

John Randolph HOSPITAL

PROVIDER #490020

October 26, 1987

Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Gentlemen:

We are in receipt of the mortality rates which pertain to John Randolph Hospital. We are pleased to note that overall our mortality rates are well within your published range of predicted rates.

It has been the practice of John Randolph Hospital for many years to review all mortalities in their respective departmental audit committee. This is an ongoing cooperative effort between physicians, administration and staff to assure the very best care for the citizens of our community.

We appreciate receiving this data in advance of its press release and the opportunity to respond.

Sincerely,

David Layman

David A. Layman, M.D.
Physician Advisor

Franklin D. Boyce

Franklin D. Boyce
Chief Executive Officer

DAL/FDB/bg

411 West Randolph Road • P.O. Box 971 • Hopewell, Virginia 23860 • 804-541-1600

Supporting our region's healthcare as part of the SunHealth network.

Johnston Memorial Hospital

October 27, 1987

William L. Roper, M.D.
Health Care Financing Administration
Health Standard Quality Bureau
Hospitality Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

We have reviewed the Medicare mortality data you sent to us last month. Of the 162 deaths reported by HCFA in 1986, 23 were reported to have expired after discharge from JMH. We assume their causes of death were the same as the principal diagnosis upon discharge.

Our review has identified discrepancies on five of our patients. Those discrepancies are as follows:

Incorrect Dates of Death

[redacted] 044 F - Exp. 3-22-86 instead of 3-31-86

[redacted] Exp. 2-13-86 instead of 2-28-86

Incorrect Admission/Discharge Dates

[redacted] Admitted 4-17-86 Exp. 5-1-86

[redacted] Admitted 1-16-86 Exp. 1-24-86

Patient Still Alive

[redacted] Reported expired on 2-13-87. Patient is still alive.

We appreciate the opportunity to review your data and to reply to it. Thank you, in advance, for correcting your records to indicate the appropriate result.

Sincerely,

Robert L. Kay

Robert L. Kay, F.A.C.H.E.
Administrator

RLK:anm

COURT STREET • ABINGDON, VIRGINIA 24210 • (703) 628-3121

COMMENTS TO HCFA
ON MORTALITY INFORMATION

HOSPITAL ID NUMBER - 490028

Johnston-Willis Hospital has a continuing program of evaluation of mortality data incorporated in its review of the quality of patient care.

The HCFA data have been reviewed. Comments follow:

A) The HCFA sample of 1638 reported cases apparently are the total number of Medicare patients whose last 1986 admission occurred at Johnston-Willis Hospital. Johnston-Willis Hospital has no means to verify this number. There were a total of 2833 Medicare admissions to Johnston-Willis Hospital in 1986.

B) HCFA reported deaths of 178 within 30 days of admission, either in the Hospital or post discharge, agrees with Hospital records. However, of the reported 178, Hospital records reflect 19 of those deaths were post discharge vs. HCFA's reported 24.

C) With regard to the diagnostic category of sepsis, 7 of 9 (78%) which expired within 30 days of admission were terminally ill with endstage renal disease and malignancies.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

King's Daughters' Hospital

COMMITTED TO CARING

COMMENTS ON THE HCFA MORTALITY DATA

King's Daughters' Hospital, Staunton, Virginia

Medicare Provider No. 49-0029

The following comments are provided in response to the HCFA Mortality Report.

1. The data used by HCFA states that a total of 196 Medicare patients admitted to King's Daughters' Hospital during 1986 died within 30 days of admission. Of these patients, 169 died while still a patient in the hospital and 27 died after discharge. While we are able to confirm the 169 patients identified by HCFA who died in the hospital, we are unable to confirm the 27 patients who were reported to have died after discharge or the cause of their death.

2. We understand the number of "cases" used by HCFA represents the number of Medicare beneficiaries whose last hospital admission during 1986 was to this hospital. Without the benefit of HCFA's information we are unable to reconcile this number through our internal review of the 2633 Medicare beneficiaries admitted to King's Daughters' Hospital during 1986.

3. The results of the reduction in cases as reported by HCFA, 1601, as compared to our actual number of admissions, 2633, accounts for a 39.2% variance. By reducing the number of cases, the mortality rates are thereby inflated. As an example, when we compare 196 reported deaths to the 1601 reported cases, the percentage is 12.2. When the same 196 deaths are compared to our 2633 actual admissions, the percentage is reduced to 7.4. This amounts to a 4.8% higher variance between the rate reported by HCFA and the rate based on actual admissions. This same rationale would then follow for each of the diagnostic categories causing each of these to also be possibly inflated.

4. Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in their analysis.

5. Our hospital Quality Assurance program includes a review of all deaths which occur in our hospital. This review process involves a review of all deaths using expected/explained criteria. If the death does not meet this criteria, it is further reviewed by the Medical Staff service committee, where quality and appropriateness of care are assessed. Findings from this review process have not revealed any deaths which have demonstrated any problems in quality or appropriateness of the medical management.

Our hospital supports the AHA, Joint Commission and others who have indicated that clinical or outcome indicators, such as mortality, are not direct measures of quality, but are more useful for identifying possible problem areas for peer review.

10/27/87

SENTARA LEIGH HOSPITAL, NORFOLK, VIRGINIA
MEDICARE MORTALITY RATE

DATA VERIFICATION:

The data used by HCFA indicates that of a total of 2,080 Medicare patients admitted to Sentara Leigh Hospital in 1986, 217 patients died within 30 days of admission. Of these deaths, 185 died while still a patient of the hospital, while 32 died after discharge.

Upon reviewing the above data, our hospital records indicate that 3,482 Medicare admissions occurred in 1986. Presumably the discrepancy in totals reflects multiple admissions of individual beneficiaries to different hospitals. Upon reviewing the HCFA list of Medicare deaths for Sentara Leigh Hospital, of the 217 patients listed, 216 patients were treated at Sentara Leigh Hospital in 1986 as follows:

- 192 died while still a patient of the hospital.
- 25 (12%) died after discharge (see attached listing of 7 patients with an incorrect date of death).
- One patient was a trauma patient at Sentara Norfolk General Hospital not Sentara Leigh Hospital (see attached listing).

Sentara Leigh Hospital is unable to verify the death of those 25 patients listed as dying after discharge as such information is not included in the patient's medical record. Upon reviewing the records of those patients, 7 patients were discharged with terminal cancer, 11 patients were transferred to extended care facilities due to comorbid medical conditions, 1 patient was transferred to a psychiatric facility for further care, and the remaining 6 patients were discharged to home with multiple comorbid conditions.

INTERPRETIVE REMARKS:

In all diagnostic categories, the actual mortality rate for Sentara Leigh Hospital falls within the range of predicted mortality rates.

It should be noted that with the HCFA acuity index for an average medicare patient being 1.0, the medicare casemix index for Sentara Leigh Hospital is 1.246.

As part of the medical staff Quality Assurance Program for Sentara Leigh Hospital, all hospital deaths are reviewed within the respective medical staff departments on a monthly basis.

CORRECTIONS
MEDICARE MORTALITY REPORT
SENTARA LEIGH HOSPITAL, NORFOLK, VIRGINIA

PATIENT ID #	SURNAME	CATEGORY	DATE OF ADMISSION	DATE OF DISCHARGE	HCFA DATE OF DEATH	ACTUAL DATE OF DEATH
[redacted]		CA	03/06/86	03/10/86	03/31/86	03/10/86
		CA	11/10/86	11/14/86	11/17/86	11/14/86
		CE	11/15/86	11/16/86	11/30/86	11/16/86
		CE	12/30/85	01/04/86	12/30/85	01/04/86
		HS	12/08/85	12/10/86	12/11/86	12/10/86
		ME	10/27/86	11/02/86	11/03/86	11/02/87
		TR	11/18/86	11/21/86	11/22/86	11/21/86

NOT TREATED AT SENTARA LEIGH HOSPITAL:

[redacted]		UN	03/28/86	03/29/86	03/29/86	

VA 49.1

MJH
Martha Jefferson Hospital
459 LOCUST AVENUE • CHARLOTTESVILLE, VA 22901 • (804) 293-0111

October 26, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, DC 20201

Dear Dr. Roper:

We have received the mortality data the Health Care Financing Agency has developed regarding Medicare patients treated here. Martha Jefferson Hospital (MJH) is a not-for-profit community hospital licensed for 221 beds. The hospital serves the Charlottesville/Albemarle community where we are located, plus the surrounding rural counties in central Virginia. MJH provides a broad range of primary and secondary level care through our 125 medical staff members. Given the accessibility of tertiary care in the community, MJH does not treat trauma patients or those requiring cardiac or neurological surgery.

Although MJH treats a wide variety of patients, approximately 40% of admissions were for individuals over 65 whose care was reimbursed by Medicare. As part of MJH's commitment to providing a wide range of services and since we have several oncologists, we work with the local Hospice program. Given the terminal condition of these patients, this program influences the mortality data for MJH.

Martha Jefferson Hospital is very concerned about the quality of care patients receive. We have a quality assurance program to assure high standards are maintained. This program is an ongoing prospective and retrospective process. The hospital evaluates cases on a number of criteria that have been developed by the Medical Staff and affected hospital departments. These indicators are used by the Quality Assurance staff which report findings to the medical sections, hospital departments and Quality Assurance Committee.

Any variances from established norms are investigated and appropriate action is taken. All "variances" in quality levels are reviewed by the Quality Assurance Department and as

appropriate by the Quality Assurance Committee. By incorporating a number of variables, MJH is able to measure the overall quality of care from a broad perspective.

Evaluating "outcome" or mortality is an important element of our overall quality assurance program. However, we have some concerns about the methodology that was used to develop the data you have prepared. The cases were categorized by principal diagnosis and does not account for the primary diagnosis for which the patient was treated. For example, if an individual was admitted for a hip fracture and died from a massive coronary while in the hospital, the death would have been compared to expected mortality rates for hip fractures, resulting in misleading information.

Another weakness in the methodology relates to incorporating deaths that occur within 30 days of discharge from the hospital. HCFA assumes that the death is related to the original principal diagnosis. Again, an individual could have been hit by a car or died of an unrelated condition. There is no way to verify the cause of death on a case by case basis without intruding on the privacy of the deceased's family.

The data you have prepared for Martha Jefferson Hospital indicates a mortality rate within the predicted ranges. After reviewing the data in our Medical Records Department, some minor discrepancies were noted, but the differences we could identify do not materially change the recorded rates. Although the mortality data reviewed here is useful, it is but one of many indicators that can be used to determine the overall level of care delivered. I look forward to HFCA preparing information that takes a broader view of how to measure "quality."

Sincerely,

John Holly
President

emb

cc: Board Executive Committee
Medical Executive Committee

A Bernardine Sisters, O.S.F. Facility

MARY IMMACULATE HOSPITAL

October 16, 1987

Administrator
Health Care Financing Administration
Department of Health and
Human Services
Washington, D.C. 20201

RE: Mortality Data for Provider #49-0041

Dear Sir:

The information which you provided us with in your letter of September 21, 1987, dealing with mortality information for Medicare patients in 1986, appears to be both incomplete and in at least one incidence, inaccurate. The inaccuracy is patient I.D. #[redacted] who is listed as having died, but who is still alive. Our billing office inaccurately coded the discharge status on her bill as deceased. I believe your computers will still show her as being very much alive and receiving Medicare and Social Security benefits. The incompleteness of the data is apparent in that total cases reviewed were 511, whereas the Hospital actually treated approximately 850 Medicare patients on an inpatient basis during 1986.

Based on my review, it does not appear that the mortality data is either complete or accurate enough for public release at this time.

Yours very truly,

James R. Larsen, CPA, FHFMA
Senior Vice President,
Fiscal Services

JRL:cah

800 Denbigh Boulevard. Newport News, Virginia 23602-4499
(804) 872-0100



October 26, 1987

Healthcare Financing Administration
Department of Health and Human
Services
Att: HSQ-148-GNC
P. O. Box 26676
Baltimore, Maryland 21201

Dear Sir:

We have reviewed the mortality data developed for our institution and have concluded that, following a brief validation, the data appears "relatively accurate". However, there are serious reservations about its applicability as a quality measure, which I understand is the impetus behind the creation of the data base. Based on our review it is our belief that the application of the data, given its statistical basis, to an area as complex as quality monitoring is spurious and misleading.

Our institution has developed an elaborate and extensive review mechanism to examine the performance of our clinicians. These quality monitoring activities consider many variables, of which mortality data is but one component. It is our belief, which is shared by most in the industry, that mortality statistics by themselves do not measure quality. They must be blended with a number of qualitative and quantitative factors to properly assess the quality of care rendered by the practitioner. In our institution a variety of screens are in place and reviewed systematically by clinicians to determine overall quality by medical discipline. This data is in turn assessed by a designated Board committee, consisting of representatives from the medical staff, management and the Board, which is responsible for hospital and medical staff quality assurance. We believe that this thorough process is clearly a more accurate form of appraisal since it considers many factors of medical care to ultimately determine a level of quality by individual practitioner and discipline.

An example of the misleading impression the data portrays for our institution is best described by the cancer classification. Our mortality rate is slightly above the expected range. We believe that the characteristics of our patient population, e.g. high patient acuity, in combination with our status as a sole community provider and rural referral center contribute to a higher morality rate than might be expected. In 1985 we opened the Cancer Center of Virginia, the only freestanding cancer treatment center within a 50-mile radius. This specialized facility provides state-of-the-art radiation oncology services to cancer patients who previously went elsewhere for cancer treatment. Our market

2300 Fall Hill Avenue, Fredericksburg, Virginia 22401
(703) 899-1100

statistics also tell us that not only are we retaining more cancer patients, but we are attracting new ones from market areas not previously tapped. This has resulted in patient acuity levels that are higher than the expected, given the increasing number of terminally ill cancer patients that we now treat. Through our quality assurance process, we monitor performance of the cancer program to assure excellence in patient care and outcome. The screening mechanism used goes well beyond the limited scope of mortality data such as that provided by your agency. The process examines the multidimensional aspects of cancer treatment to properly evaluate quality. We believe that according to the extensive review undertaken by our quality monitoring activity our cancer program is an excellent clinical service, something that is not evident if you only consider mortality statistics to the exclusion of many other monitoring criteria.

The subject of quality determination for the healthcare industry has undergone extensive review and development for many years, especially by the Joint Commission on the Accreditation of Hospitals as they develop uniform standards applicable industrywide. Clearly, healthcare must adopt rigorous quality standards to assure that appropriate patient care is rendered. Through the efforts of organizations, such as the JCAH and the hospital industry, meaningful and accurate quality monitoring activities have been developed and is in a constant state of evaluation to further refine the process. Based on our review of the methodology and applicability of the mortality data presented, we can find little relevance between HCFA's objective of quality determination and actual practice, and further state this effort falls well short of any usefulness in informing the public.

Sincerely,

Joseph R. Swedish
Executive Vice President

JRS/kse

2949 West Front Street
Richlands, Virginia
24641
Telephone 703 963-0811

Humana Hospital
Clinch Valley

September 29, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

This letter is to inform you that the Mattie Williams is no longer in business. Therefore, I am returning to you the mortality information on Medicare patients.

If there are any questions, please let me know.

Respectfully,

W. A. Gillespie

W. A. Gillespie
Executive Director

WAG/ksh

Enclosure

Medical College of Virginia Hospitals
Virginia Commonwealth University

October 27, 1987

William L. Roper, M. D.
Administrator
Health Standards & Quality Bureau
Room 2D2
Meadows East Building
6300 Security Boulevard
Baltimore, Maryland 21207

Dear Dr. Roper:

I am writing to share my comments regarding the proposed December release of HCFA mortality data. Our brief time to preview the data confirms the inappropriateness and limited value of this action.

The industry, as well as your organization, has outlined the shortcomings of your statistical model. It has advanced in sophistication from the first release of this type of data but does not yet provide a credible picture of the quality of a hospital. It is unfortunate, for the public is likely to assume this tool to be more credible than it is and, in the process, some longstanding and worthy reputations will be harmed.

Your own comments in the August 17, 1987 issue of the Federal Register reinforces this concern. "First not all of the factors affecting the probability of death in a particular case, most notably severity of illness, are included in the predictive model because information on them is not readily available. Thus, a difference between a hospital's actual and expected mortality rates cannot definitely be construed as reflecting especially high or low quality of care".

The question then becomes what benefit does this exercise provide as an offset to the possible risk of misinformation at best or institutional character assassination at worst.

As a tertiary care institution with a broad range of services and teaching mission, the adequate incorporation of characteristics of our patient mix is of great concern in any statistical modeling. Referral of the most complicated case, major trauma, high risk organ transplant, is a measure of our success as a major medical center. The inference of your statistics can paint a different picture. Our concern over your methodology is not based on our own poor performance. Our data in your report are within or below all predicted ranges. Our concerns are the flaws in the approach.

MCV Hospitals Administration • P.O. Box 510 • Richmond, Virginia 23298-0001 • (804) 786-4682

Specifically, a look at your approach suggests:

1. The variables used are measured in their relationship to death rates but these are not all the variables that affect deaths;

2. Deaths unrelated to the hospitalization are included as a result of the criteria to use all deaths within 30 days of the admission;

3. The data is incorrect. On the attachment we have provided corrections to the errors which included incorrect inclusion of expirations beyond the 30 day limit, incorrect category coding of type of disease and incorrect expiration dates.

Additionally, case specific review of cases in the Trauma, Gastrointestinal, and Urology areas identified the following concerns:

4. While "selected co-morbitities" were included in your model it is not clear how this impacts the data. In several categories of our patients virtually all deaths involved extensive multiple system failures as well as the principle diagnosis reported;

5. A number of patients were at the end of the disease process and were in fact admitted with Do Not Resuscitate orders;

6. Many were transfers from nursing homes;

7. As a Level I Trauma Center the intensity of trauma noted in these cases was well above average.

These errors and the basic weakness of the system design produces an incomplete statistical picture. The potential public consumption of this data or representation of this as a vehicle to differentiate institutional quality is shortsighted and unnecessary.

Thank you for the opportunity to comment.

Sincerely,

Carl R. Fischer
Executive Director

CRF/dh

CLASSIFICATION CHANGES - Principal diagnosis different than that listed by HCFA
- Principal diagnosis listed by MCVH is verified by PRO

1) [redacted] 4/3/86 to 4/5/86

Change principal diagnosis from 5789 to 86800
Change classification from GC to GI

2) [redacted] 9/9/86 to 9/11/86

Change principal diagnosis from 585 to 71596
Change classification from RN to OP

3) [redacted] 3/14/86 to 3/31/86

Change principal diagnosis from 5845 to 9953
Change classification from RN to UN

4) [redacted] 4/7/86 to 4/22/86

Change principal diagnosis from 1623 to 5920
Change classification from CA to RN

5) [redacted] 11/15/86 to 11/21/86

Change principal diagnosis from V580 to 4349
Change classification from UN to CE

INVALID EXPIRATION DATE - dates verified via the Virginia Bureau of Vital Statistics

1) [redacted] to 1/21/86 (CA)

HCFA expiration date - 2/7/86
Verified expiration date - 7/27/86

*Expired more than 30 days from admission; therefore, should be excluded from statistics. Classified as CA.

2) [redacted] 8/7/86 to 8/14/86 (CA)

HCFA expiration date - 8/31/86
Verified expiration date - 8/16/86

3) [redacted] 7/20/86 to 7/21/86 (GI)

HCFA expiration date - 7/31/86
Verified expiration date - 7/25/86

4) [redacted] 8/7/86 to 8/22/86 (GU)

HCFA expiration date 8/31/86
Verified expiration date - 8/29/86

5) [redacted] 7/11/86 to 7/23/86 (HL)

HCFA expiration date - 7/31/86
Verified expiration date - 7/24/86

6) [redacted] 2/17/86 to 2/21/86 (HM)

HCFA expiration date 3/8/86
Verified expiration date - 3/28/86

*Expired more than 30 days from admission; therefore, should be excluded from statistics. Classified as HM.

7) [redacted] 9/8/86 to 9/15/86 (PN)

HCFA expiration date - 9/19/86
Verified expiration date - 9/27/86

8) [redacted] 3/26/86 to 3/27/86 (PN)

HCFA expiration date - 3/29/86
Verified expiration date - 3/30/86

9) [redacted] 1/30/86 to 2/8/86 (PN)

HCFA expiration date - 2/28/86
Verified expiration date - 2/13/86

10) [redacted] 8/6/86 to 8/26/86 (PN)

(See next page)

10) [redacted] 8/6/86 to 8/26/86 (PN)

HCFA expiration date - 8/31/86
Verified expiration date 8/26/86

11) [redacted] 9/3/86 to 9/3/86

HCFA expiration date - 9/30/86
Verified expiration date - 9/3/86

12) [redacted] 4/18/86 to 4/25/86 (UN)

HCFA expiration date - 5/10/86
Verified expiration date - 5/19/86

*Expired more than 30 days from admission; therefore, should be excluded from statistics. Classified as UN.

13) [redacted] 7/6/86 to 7/13/86 (UN)

HCFA expiration date - 7/31/86
Verified expiration date - 7/20/86

14) [redacted] 1/11/86 to 1/18/86 (UN)

HCFA expiration date - 1/31/86
Verified expiration date - 1/18/86

Memorial Hospital
of Martinsville & Henry County

October 13, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

This letter is in reply to your letter of September 21, 1987, concerning planned publication of selected 1986 Medicare patient mortality information about this hospital. Memorial Hospital of Martinsville and Henry County is the only hospital in its city/county primary service area of approximately 77,000 population. It also serves patients from four surrounding counties, especially Patrick County, Virginia, to the west, which has 18,210 population. MHMHC is categorized as a Medicare Rural Referral Hospital because of its inpatient volume, patient mix, and number of medical staff specialists. It operates an Emergency Department, chemotherapy cancer progarm, a hospice program, an obstetrical and pediatric service, a psychiatric unit, and other services generally found in full-service community hospitals. There are two intermediate care nursing home facilities in Martinsville with a total licensed capacity of 323 beds and a similar facility in Stuart, Patrick County Virginia, with 120 licensed beds. The point is that there is a concentration of elderly patients who come to this hospital when hospitalization is required.

As reflected in the attachment, there are some inaccuracies in the data which was attached to your letter. For example, there were 258 total deaths, not 259. In addition, only 25 deaths occurred after discharge, not 32 deaths as identified in the attachment to your letter. Four cases reflected incorrect coding of the principal diagnosis. Two cases reflected incorrect coding of the principal procedure and three cases reflected incorrect assignment of diagnostic category. Overall, we do not believe that these errors in reporting are statistically significant.

Of significance to us is the MHMHC case mix by age and the diagnostic category grouping reflecting cause of death. The mix by age is as

follows: Age 90+ - 22 deaths; ages 80-89 - 88 deaths; ages 70-79 - 104 deaths; ages 50-69 - 42 deaths; less than age 50 - 2 deaths. A review of the causes of death as reflected in the diagnostic category grouping and of the case mix by age reflects that the majority of deaths occurred in elderly, very sick patients.

We are happy to note that all of the actual mortality rates by diagnostic category for MHMHC fell within the range of predicted mortality rates. We feel that all deaths are explainable by the patient's diagnosis, age, severity of illness, and by other environmental and life style factors common to our rural location. We feel that MHMHC offers an outstanding quality of care to the patients it serves.

Sincerely,

Clyde L. Britt
Executive Director

CLB:jc
Attachment

Memorial Hospital
of Martinsville & Henry County

The following discrepancies have been identified in the HCFA Mortality Data submitted for the year 1986:

259 Deaths identified by HCFA is an incorrect total. Two (2) different patients were listed with the same identification, etc. One patient (Willis) was not a patient in this hospital during the time frame used by HCFA.

258 Corrected total deaths.

32 Deaths identified as occurring after discharge data incorrect. Correct figures are: 25.

7 Occurred on patients admitted to and discharged from the hospital, 2 of these occurring in the year subsequent to admission.

5 Deaths occurred in the Emergency Room.

7 Patients were DOA on arrival to the Emergency Room.

13 Site of death undetermined but have been identified on the attached list, excluding 2 which we were unable to obtain information on.

4 Cases incorrect coding of principal diagnosis.

2 Cases incorrect coding of principal procedure.

3 Cases incorrect assignment of diagnostic category.

COMMENTS:

Data submitted and used by HCFA to reflect mortality review for MHMHC is not accurate as evidenced by the above statements and the attached research data. Cause of death may not have been accurately concluded. Numerous patients had severe complicating secondary diagnoses which could result in death other than that identified by HCFA. Example, a number of patients had known metastatic disease which may have been the actual cause of death other than the admitting and principal diagnosis.

Additionally, although the age case mix is assumed to be included in the data, we would be interested in seeing the breakdown of other hospitals in the Southeast.

MHMHC CASE MIX BY AGE:

90+ =	22
80-89=	88
70-79=	104
50-69=	42
-50=	2

The above age groups are taken directly from the report submitted by HCFA.

We also wonder if the fact that MHMHC provides Hospice services has been recognized in the data.

320 Hospital Drive • P.O. Box 4788 • Martinsville, Virginia 24115-4788 • Telephone: (703) 666-7200

HCFA MORTALITY DATA: YEAR OF 1986

DIAGNOSTIC CATEGORY GROUPING:

1. PULMONARY DISEASE: 40 (22%) (Total includes the 3 cases incorrectly assigned to other diagnostic categories)
   - 5 patients had active CA
   - 5 had respiratory failure
   - 4 had septicemia
   - 3 had congestive heart failure
   - 4 had cardiac arrest
   - 3 had acute renal failure
   - 1 had heart failure
   - 1 had staph and bacterial infection

   14 Review did not reflect any additional diagnoses that might have contributed to cause of death.

2. SEVERE ACUTE HEART DISEASE: 35 (49%)
   - 26 patients had acute MIs.
     - 10 had history of previous MI
     - 3 had cardiac arrest
     - 5 had cardiogenic shock
     - 1 had inferior and anterior wall MIs
     - 1 had respiratory failure and acute renal failure
     - 1 had cerebral embolism
     - 1 had cerebral artery occlusion

   4 Review did not reflect any additional diagnoses that might have contributed to cause of death, other than the MIs.

   5 patients admitted in cardiac arrest, 2 of which had history of previous MIs.

   2 patients admitted with paroxysmal ventricular tachycardia, both went into cardiac arrest, 1 with respiratory failure.

   1 patient had ruptured abdominal aneurysm with shock, MI, and cardiac arrest.

   1 had cardiogenic shock with CHF and old MI.

3. CEREBROVASCULAR ACCIDENTS: 23 (38%)
   - 11 cerebral artery occlusion, unspecified
     - 4 had previous MIs.
     - 3 had CHF and/or left heart failure
     - 1 had respiratory failure
     - 1 had chronic renal failure and cardiac arrest.
   - 4 cerebral thrombosis.
     - 1 had CHF
     - 1 had Staph and bacterial infection with cardiac pacemaker status.
     - 1 had orthostatic hypotension
   - 4 intracerebral hemorrhage
     - 1 had pneumonia.
     - 1 had E coli, pseudomonas and bacterial infection.
   - 3 subarachnoid hemorrhage.
     - 1 subdural hemorrhage plus pneumonia and hypertension
     - 1 hypertensive
     - 1 cardiac arrest
   - 1 subdural hemorrhage

HCFA MORTALITY DATA: YEAR OF 1986

DIAGNOSTIC CATEGORY GROUPING:

4. GASTROINTESTINAL CATASTROPHES: 5 (14%)
   3 patients had hemorrhage of G.I. unspecified.
   1 had cardiac arrest with MI and pneumonia
   1 had cardiac arrest, staph pneumonia and septicemia
   1 had renal failure

   1 patient had intestinal or peritoneal adhesions with obstruction; also had cardiac arrest, renal failure and pneumonia.

   1 patient had acute and subacute necrosis of liver with cirrhosis of liver and bleeding esophageal varices

5. METABOLIC/ELECTROLYTE DISTURBANCES: 10 (20%)
   8 patients had volume depletion disorder
   5 had metastatic disease, 1 with heart failure.
   1 had aspirational pneumonitis as well as pneumonia
   2 had other conditions that would probably not be used in computing the DRG

   1 patient had fluid overload disorder with GI hemorrhage and cardiac arrest

   1 patient had renal failure with cardiac dysrhythmia

6. ORTHOPEDIC DISORDERS: 2 (2%)
   1 patient had closed fracture upper end of fibula with tibia; also had MI and CHF as secondary diagnoses
   1 patient had pathological fracture; also had metastatic carcinoma

7. SEPSIS: 8 (47%)
   2 patients had septicemia due to gram-negative organism, unspecified; 1 also had shock w/o trauma, pneumonia and cardiac arrest, and 1 had metastatic CA.
   2 patients had other septicemia due to gram-negative organisms; 1 had additional diagnoses of pneumonia, renal failure and metastatic CA; 1 had shock w/o trauma and cardiac arrest.
   2 patient had unspecified septicemia, 1 with a proteus infection and 1 with COPD and left heart failure.
   1 patient had staphyloccocal septicemia with cirrhosis of liver
   1 patient had septicemia due to anaerobes with cardiac arrest and CHF.

8. SEVERE TRAUMA: 2 (4%)
   2 fracturesof intertrochanteric section of femur closed with CHF,COPD and aspirational pneumonitis in one case and paralytic ileus occurring in the second case.

9. RENAL DISEASE: 10 (31%) Total does not include the patient incorrectly assigned to Renal.
   5 patients had renal failure unspecified.
   1 had GI hemorrhage with metastatic CA
   1 had hypertensive/heart renal disease with E coli and pseudomonas infection.
   1 had COPD, metastatic CA and respiratory failure.
   1 had unspecified septicemia and acidosis with pneumococcal pneumonia.
   1 had metastatic CA.

   2 patients had chronic renal failure, 1 with hypertensive renal disease and CA of bronchus/lung, 1 with CHF.

   1 patient had acute renal failure, unspecified with hypovolemia

HCFA MORTALITY DATA: YEAR OF 1986:

DIAGNOSTIC CATEGORY GROUPING:

9. RENAL DISEASE cont..:
__1__ patient had unspecified pyelonephritis with myasthenia gravis and COPD.

__1__ patient had acute pyelonephritis without lesion of renal medullary necrosis with additional diagnosis of MI.

__1__ patient listed under this category INCORRECTLY. Patient had principal diagnosis of PNEUMONIA with secondary diagnoses of acute renal failure and acute pancreatitis. This case should have been listed under PULMONARY DISEASE.

10. SEVERE CHRONIC HEART DISEASE: 24 (19%) Total does not include the 2 incorrectly assigned to this diagnostic category.
__16__ patients had CHF
__5__ patients had cardiac arrest.
__2__ patients had COPD and atrial fib.
__1__ patient had COPD
__1__ patient had atrial fib and old MI
__1__ patient had cardiogenic shock
__1__ patient had pneumonia, GI hemorrhage and staph infection
__1__ patient had cardiac pacemaker status and hupertensive renal disease
__1__ patient turned in as acute MI; with CHF as secondary diagnosis;however chart appears on the CHF list. Patient expired 2nd day of admission.
__3__ patients had secondary diagnoses which probably would not have attributed to death.

__3__ patients had unspecified hypertensive heart disease with CHF, 1 of these also had renal failure, acidosis, cardiogenic shock,old MI and COPD. The other 2 had other conditions probably not pertinent to the cause of death.

__4__ patients had left heart failure, __2__ with additional diagnoses of old MI , __1__ with renal failure and the other case probably had an insignificant secondary diagnosis.

__1__ patient had other primary cardiomyopathies with left heart failure, atrial fig and COPD

__2__ patients were included in this list INCORRECTLY. They had pulmonary diagnoses and should have been on that list.

11. LOW RISK HEART DISEASE: 8 (8%)
__1__ patient with cardiac arrest had MI, CHF, and malfunctioning cardiac pacemaker as secondary diagnoses.
__1__ patient with unspecified hypertensive renal disease.
as secondary diagnoses.
__1__ patient with unspecified hypertensive heart disease had cardiac arrest and pulmonary embolus as secondary diagnoses.
__1__ patient with unspecified angina had left heart failure and cardiac arrest.
__1__ patient with other specified forms of chronic ischemic heart disease had cardiac arrest
__1__ patient with ch pulmonary heart disease had heart failure, COPD and respiratory failure
__1__ atrial fibrillation with cerebral embolism
__1__ other specified cardaic dysrhythmias with CVA

HCFA MORTALITY DATA: YEAR OF 1986

DIAGNOSTIC CATEGORY GROUPING:

12. GASTROINTESTINAL DISEASE: 7 (3%)

__2__ patients with perforation of intestine; __1__ had unspecified peritonitis and shock w/o trauma; __1__ patient had metastatic CA

__1__ patient had unspecified gastritis and gastroduodenitis with CHF

__1__ patient had paralytic ileus with metastatic CA, G.I. hemorrhage and cardiac arrest.

__1__ patient had hemorrhage of rectum and anus with cardiac arrest and suspected malignancy

__1__ patient had malfunction of colostomy and enterostomy with MI as secondary diagnosis.

__1__ patient had calculus of gallbladder without cholecystitis or obstruction with secondary diagnoses of surgical complication of respiratory system and GI. tract, cardiac arrest, renal and pulmonary collapse as well as paralytic ileus

13. UROLOGIC DISEASE: 7 (4%)

__3__ patients with UTI, site not specified.
1 had staph and pseudomonas septicemia
1 had shock without trauma
1 had cardiac arrest

__1__ patient had BPH with cardiac arrest and cardiac pacemaker status

__1__ pyelonephritis, unspecified, also had shock w/o trauma and cardiac arrest

__1__ other specified type of cystitis with aspirational pneumonitis and angina

__1__ unspecified disorder of kidney and ureter with pacemaker status

HOSPITAL = 490079 MEMORIAL HOSPITAL MARTINSVILLE MARTINSVILLE VA

	DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE		RANGE OF PREDICTED MORTALITY RATES
	ALL CAUSES	1,937	13 %		8 TO 15 %
	CA - CANCER =39	121	32 %		16 TO 35 %
# 3	CE - CEREBROVASCULAR ACCIDENTS = 23	60	38 %		16 TO 39 %
	EY - OPHTHALMOLOGIC DISEASE	6	0 %		0 TO 100 %
# 4	GC - GASTROINTESTINAL CATASTROPHES=5	96	14 %		6 TO 32 %
#12	GI - GASTROINTESTINAL DISEASE =7	221	3 %		1 TO 8 %
#13	GU - UROLOGIC DISEASE=7	162	4 %		1 TO 11 %
	GY - GYNECOLOGIC DISEASE	22	0 %		0 TO 83 %
#11	HL - LOW-RISK HEART DISEASE =8	95	8 %		1 TO 10 %
#10	HM - SEVERE CHRONIC HEART DISEASE =24	127	20 %	19%	14 TO 29 %
# 2	HS - SEVERE ACUTE HEART DISEASE =35	71	49 %		27 TO 50 %
# 5	ME - METABOLIC/ELECTROLYTE DISTURBANCES =10	49	20 %		10 TO 36 %
# 6	OP - ORTHOPEDIC DISORDERS =2	125	2 %		0 TO 7 %
# 1	PN - PULMONARY DISEASE =41	106	20 %	22%	13 TO 26 %
# 9	RN - RENAL DISEASE=10	92	34 %	31%	11 TO 47 %
# 7	SE - SEPSIS=8	17	47 %		16 TO 61 %
# 8	TR - SEVERE TRAUMA =2	54	4 %		3 TO 19 %
	UN-All other conditions=37				

VA 62.7

REVIEW OF HCFA MEDICARE MORTALITY DATA

259 Deaths submitted from HCFA. 1 Case duplicated. Corrected total is 258. [redacted] both admitted on 5/30, expired 06/11/86. Data listed pertains to a Moore. We had no patient by the name of [redacted] expiring in the hospital in 1986.

32 Deaths identified as occurring after discharge date.

OF THESE

7 Deaths occurred on patients admitted directly to the hospital, 2 in year subsquent to admiss.

5 Deaths occurred in E.R.

7 DOAs

13 Site of death undetermined, see list below:

DEATHS OCCURRING ON ADMITTED PATIENTS. (Listed as death occurring after discharge) = 7

PATIENT ID#:	SURNAME:	DIAGNOSTIC CATEGORY:	A/S:	DATE OF ADMIT:	DISCHARGE DATE:	DATE OF DEATH:	PRINCIPAL DIAGNOSIS:	PRINCIPAL PROCEDURE:
[redacted]	[redacted]	CE	71/M	12/05/86	12/05/86	12/05/86	430.	
		HS	78/M	07/31/86	08/02/86	08/02/86	410.4	
		PN	84/M	10/23/86	11/17/86	11/17/86	482.0	
		UN	86/F	03/29/86	03/30/86	03/30/86	785.59	
		UN	77/F	12/14/86	12/29/86	12/29/86	710.9	
*		CA	66/F	12/29/86	01/02/87	01/02/87	205.1	
*		HL	81/M	12/30/86	01/04/87	01/04/87	426.0	37.75

* Deaths occurring in year subsequent to admission date.

DEATHS OCCURRING IN EMERGENCY ROOM.= 5

[redacted]	[redacted]	CE	99/F	08/19-86	09/01/86	09/11/86	434.9	
		HM	78/F	08/23/86	09/12/87	09/22-86	428.0	48.23
		HM	78/F	10/08/86	10/10/86	10/31/86	428.1	
		HS	86/F	10/17/86	10/27/86	11/10/86	410.4	
		UN	86/M	09/10/86	09/16/86	09/18/86	251.2	

DOAs. = 7

[redacted]	[redacted]	HM	75/F	09/28/86	10/06/86	10/16/86	428.0	
		HM	88/F	04/19/86	04/25/86	05/13/86	428.0	
		UN	69/M	03/25/86	03/29/86	04/12/86	293.0	
		UN	67/F	06/23/86	07/02/86	07/12/86	273.3	34.91
		UN	74/F	01/27/86	02/08/86	02/18/86	290.3	
		PN	88/M	06/29/86	07/10/86	07/18/86	486	
		PN	71/M	02/04/86	02/12/86	02/27/86	507.0	33.23

DEATHS OCCURRING OUTSIDE HOSPITAL SETTING. = 13

[redacted]	[redacted]	CA	(MCH)	71/F	09/16/86	09/22/86	10/04/86	198.3
		CA	(Home)	76/F	10/20/86	10/30/86	11/08/86	198.3
		CE	(???)	96/F	11/10/86	11/19/86	12/10/86	434.0
		CE	(Home)	86/M	11/25/86	11/27/86	11/28/86	434.9
		CE	(CHC)	74/F	10/25/86	11/07/86	11/19/86	434.9
		HM	(Home)	90/F	11/09/86	11/29/86	12/04/86	428.0
		PN	(Home)	86/M	12/15/86	12/16/86	12/31/86	519.1
		UN	(Home)	74/F	02/12/86	02/14/86	02/17/86	780.3
		UN	(MCH)	88/F	10/11/86	10/20/86	10/31/86	780.3
		CA	(Home)	71/M	07/23/86	07/30/86	08/16/86	185 60.2
		ME	(???)	94/F	06/24/86	07/03/86	07/12/86	276.5
		PN	(Home)	78/F	08/09/86	08/16/86	08/19/86	515 33.24
		UN	(CHC)	78/f	12/23/85	01/06/86	01/09/86	707.0

CODING ACCURACY.

PRINCIPAL DIAGNOSIS CODE: (4 Incorrect codes identified by HCFA as principal)

ID #:	SURNAME:	DIAGNOSTIC CATEGORY:	A/S:	DATE OF ADMIT:	DISCHARGE DATE:	HCFA LISTED	CORRECT CODE:
[redacted]	[redacted]	GU	73/F	09/30/86	10/05/86	599.0	590.80
[redacted]	[redacted]	HM	81/F	07/10/86	07/21/86	428.0	482.4
[redacted]	[redacted]	RN	69/M	05/20/86	05/22/86	586	486
[redacted]	[redacted]	SE	72/F	12/23/86	01/08/86	038.9	038.3

PRINCIPAL PROCEDURE CODE: = 2

[redacted]	[redacted]	GI	71/M	03/14/86	04/08/86	44.11	54.11
[redacted]	[redacted]	SE	78/M	05/28/86	06/15/86	38.92	38.93

INCORRECT ASSIGNMENT OF DIAGNOSTIC CATEGORY: = 3

[redacted]	[redacted]	RN	69/M	05/20/86	05/22/86	586	486
(This patient should be under PN)							
[redacted]	[redacted]	HM	80/M	09/11/86	09/14/86	518.4	
(This patient should be under PN)							
[redacted]	[redacted]	HM	81/F	07/10/86	07/21/86	428.0	482.4
(This patient should be under PN)							

MOUNT VERNON HOSPITAL
FAIRFAX HOSPITAL SYSTEM

Mount Vernon Hospital
2501 Parker's Lane
Alexandria, Virginia 22306
703 664-7000

Stephen C. Rupp
Vice President, Fairfax Hospital System
Administrator, Mount Vernon Hospital

26 October 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Meadows East Building Room 2-3-Z
6300 Security Boulevard
Baltimore, Maryland 21207

Dear Dr. Roper:

On behalf of Mount Vernon Hospital, an affiliate of Fairfax Hospital System, we thank you for the opportunity to provide comments to help the public interpret our mortality statistics. HCFA's initiative in making these statistics available is a positive step, and we support it.

Quality of care is of the utmost concern to the management and medical staff of Mount Vernon Hospital. We already have an active quality assurance program that assembles and analyzes patient care data daily. Although no one methodology can be comprehensive, the HCFA statistics provide an additional perspective from which to view our performance.

Although it has been improved, the HCFA statistical model still has limitations. Its ability to detect differences in quality has not been tested. More important, it does not account for severity of illness--how ill a patient was upon admission.

Nevertheless, when considered with other information sources, the HCFA data can provide one useful portion of an overall quality assurance program.

We look forward to working with you again in future efforts to further the public's understanding of the health care delivery system and the care they receive. Thanks again for the opportunity to comment.

Sincerely yours,

Steve Rupp

Stephen C. Rupp
Administrator

Laurence J. Clark, M.D.
Medical Staff President

RESPONSE AND COMMENTS
1986 HCFA MORTALITY DATA

Mount Vernon Hospital
Alexandria, Virginia

Introduction

Mount Vernon Hospital supports efforts that can further consumer understanding of the health care delivery system and the quality of the care they receive. There are a variety of means of measuring and communicating quality but no one methodology can satisfy all aspects of care. In short, every approach taken exclusively has its limitations.

THE HCFA mortality data is one measure that can offer some insight into evaluating health care delivery systems. It concentrates on one segment, the Medicare population, and therefore is inadequate in addressing other age groups with significantly different health concerns.

When considered with other information sources such as other professional citations, as well as physician and patient recommendations the HCFA data can be a helpful information piece in an overall evaluation of health care providers.

Data Verification/Identified Errors

- The HCFA data indicates that Mount Vernon Hospital treated 1,007 Medicare patients in 1986. Mount Vernon Hospital (MVH) records show 1,872 Medicare cases treated due to such factors, as HCFA only includes the last admission for those patients hospitalized more than once during the year.

- All deaths listed by HCFA have been verified with the exception of errors listed below.

- The following patient listed as an MVH death by HCFA does not show on any MVH records as an admission, discharge or death:

Patient ID #	Diagnostic Category	Age	Admission Date	Discharge Date
[redacted]	TR	86	12/17/85	01/08/86

- The following cases were reported as deaths after discharge by HCFA but MVH records show them as inpatient deaths.
  (see Attachment A)

Response and Comments -
1986 HCFA Mortality Data - Mount Vernon Hospital, Alexandria, VA

Comments

Actual mortality rates at Mount Vernon Hospital fall within the range of the predicted rates in all diagnostic categories. Aside from noting the hospital's performance overall we would like to make the following observations:

1. Of the 15 cases reported by HCFA as deaths after discharge

   - o Four patients were reported incorrectly and actually expired as inpatients.
   - o Four of the patients were patients discharged in the advanced stages of cancer.
   - o Other than the four cancer patients identified above there is no diagnostically identified pattern of patients dying after discharge.

2. The four leading causes of death in the Commonwealth of Virginia as reported by the Virginia Hospital Association are

   - o Heart Disease
   - o Malignant Neoplasm
   - o Cerebrovascular Disease
   - o Chronic Pulmonary Disease

   which not unexpectedly coincides with the mortality experience of the reported Medicare Cases in the HCFA data.

3. As part of its quality assurance program Mount Vernon Hospital routinely reviews all deaths in the hospital, not just Medicare cases. These deaths are reviewed by physicians either at the committee or departmental level. Although the Medicare cases had all been reviewed earlier, Mount Vernon Hospital reexamined the cases identified by HCFA and is satisfied that the quality of care provided was appropriate.

   Mount Vernon Hospital is not routinely informed of death post-discharge. Therefore it was not capable of verifying or reviewing the cause of those deaths HCFA reports as occurring after discharge.

mor.ss

Attachment A

Cases Reported as Deaths After Discharge by HCFA
Which MVH Records Show as Inpatient Deaths

		HCFA			MVH		
Patient ID #	DC	Admission Date	Discharge Date	Date of Death	Admission Date	Discharge Date	Date of Death
[redacted]	HS	05/19/86	05/26/86	05/29/86	05/19/86	05/26/86	*05/26/86
[redacted]	UN	04/09/86	04/18/86	04/19/86	04/09/86	04/19/86	04/19/86
[redacted]	UN	05/16/86	05/20/86	05/31/86	05/16/86	05/19/86	05/19/86
[redacted]	TR	12/07/86	12/11/86	12/31/86	12/07/86	12/11/86	12/11/86

DC=Diagnostic Category
* underlined dates indicate correct data

COMMENTS ON THE HCFA MORTALITY DATA
SENTARA NORFOLK GENERAL HOSPITAL
NORFOLK, VIRGINIA

DATA VERIFICATION:

The data used by HCFA indicates a total of 4,151 Medicare patients admitted to Sentara Norfolk General Hospital in 1986. Of these, 460 patients died within 30 days of admission. Of these deaths, 397 died while still a patient of the hospital, while 63 died after discharge.

Sentara Norfolk General Hospital records indicate that 6,874 Medicare admissions occurred during 1986. Presumably the discrepancy in totals reflects multiple admissions of individual beneficiaries to different hospitals.

Sentara Norfolk General Hospital is unable to verify the death of those 63 patients listed as dying after discharge as such information is not included in the patient's medical record.

In some instances, the categorization of data in the HCFA study does not appear to conform to normal groupings of patients according to diagnosis, treatment, or procedure.

INTERPRETIVE REMARKS:

Sentara Norfolk General Hospital mortality rates compare favorably with the data supplied by HCFA.

Sentara Norfolk General Hospital offers the most complex services in the Hampton Roads area and receives referrals from a wide geographic area including the Eastern shore of Virginia, Virginia localities south of Richmond, Dare County, N.C. and Northeastern North Carolina. SNGH has one of the five state-designated Level 1 Trauma Services within the State of Virginia and is supported by a hospital based air ambulance. Other services offered in the area only by Sentara Norfolk General include the Burn Unit , open heart surgery, a Neuro Intensive Care Unit, Invitro fertilization, hospice, and high risk obstetrics. SNGH also has the largest and most sophisticated cardiac program and radiation oncology program in the area.

These programs and the severity of illness of patients treated at a tertiary care center are recognized by HCFA in our assigned acuity index of 1.523. The average Medicare patient has an acuity level of 1.0.

As part of the medical staff Quality Assurance Program for Sentara Norfolk General Hospital, all hospital deaths are reviewed within the respective medical staff departments on a monthly basis.

Potomac Hospital
Corporation

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Re: Mortality Data for Potomac Hospital, #49-0113

Dear Dr. Roper:

Potomac Hospital is pleased to be given the opportunity to respond to the Health Care Financing Administration's calculated Mortality rates for Medicare patients admitted to our facility in 1986.

The delivery of quality patient care is the primary concern of Potomac Hospital's Governing Board, Administration, and Medical Staff. A comprehensive and systematic quality asurance program monitors all of our patients' care. This program is continually reviewed, evaluated, and updated to meet the demands of the rapidly changing health care industry. We at Potomac Hospital pride ourselves in delivering quality, cost-effective services to the patients of our community.

Mortality data are only a small part of our comprehensive quality assurance program. Death review has been part of the patient care evaluation process since Potomac Hospital opened 15 years ago. These data by themselves in no way measure the quality of care provided by our hospital. They can help to identify and suggest areas for more in-depth review. Along with other quality control information, these data are evaluated on a regular basis to help assess trends and variations from standards. At our facility, any indication of a potential quality assurance problem leads to an immediate and thorough review with corrective action as necessary.

Professional members of our Quality Assurance Department have reviewed, in depth, the cases listed in the data compiled by HCFA. All patients reviewed were determined to have received appropriate care. Eighty-four percent (84%) of the sixty-two (62) cases were in the end stages of their disease (i.e., patients for whom no further treatment was available or for whom no further treatment was desired by the patient or the patient's family).

2300 Opitz Boulevard, Woodbridge, Virginia 22191 (703) 670-1313

I would now like to comment on the methodology used by HCFA. The ability of this model to detect differences in the quality of care provided has never been proven and is suspect for several reasons. First, the predicted range is calculated by assuming all patients are the same. Severity of illness, how sick the patient was at the time of admission, is not measured. Second, the small numbers in many of the diagnostic categories distort the predicted ranges and the actual mortality rates. For example, the gynecologic disease category has a predicted range of 0-92%. Our rate was 25% since only four cases fell into this category, one of which died. This patient was an 86-year-old female being treated for bleeding secondary to an unknown gynecologic disease. After a few days in the hospital, the patient and her family refused further treatment. Third, it should be noted that not all Medicare admissions for 1986 were counted. Only the patient's last admission for the year is used and this tends to skew the percentage of actual and predicted death rates. The likelihood of a patient dying the last time he or she is admitted to a hospital is by definition certainly greater than on previous admissions.

In conclusion, I would like to reemphasize that Potomac Hospital is committed to the provision of quality patient care. Even though we are pleased that our mortality rate falls in the predicted range, it cannot be used as a valid measure of hospital performance. Our hospital, in conjunction with the American Hospital Association, the Joint Commission on Accreditation of Healthcare Organizations, and other concerned groups and individuals continue to work toward defining better methods for evaluating hospital care and services. Potomac Hospital is committed to this process, as we and the public need better methods of measuring the quality of care provided in our nation's hospitals.

Potomac Hospital is proud of the quality of care it provides. I would be delighted to discuss the quality of care provided at Potomac Hospital, our Quality Assurance Program, and these mortality data with any interested individuals.

Sincerely,

Wm M. Moss

William M. Moss
President

WMM:gcw:nmp
Wang #6496I

cc: Michael E. Cohen, M.D.
Chief of Medical Staff

Potomac Hospital Corporation

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

THESE ARE NOT OUR OFFICIAL HOSPITAL COMMENTS FOR THE PUBLIC REGARDING OUR MORTALITY DATA. THIS IS A SEPARATE LETTER TO INFORM YOU OF SOME OF THE DISCREPANCIES WE FOUND IN COMPARING OUR DOCUMENTATION TO YOUR DATA. OUR HOSPITAL'S COMMENTS ON THE MORTALITY DATA HAVE BEEN SENT UNDER SEPARATE COVER.

1. After extensive research, we have found no record on two of the patients whose deaths have been attributed to us:

HIC#	SURNAME
[redacted]	[redacted] . . .

2. Three patients' deaths attributed to us should have been attributed to another facility where they died prior to January 31, 1987:

HIC#	SURNAME	PLACE OF DEATH
[redacted]	[redacted]	Hospice Arlington Hospital Hospital in W. Va.

3. One patient was listed as a death after discharge but actually died during a subsequent readmission to Potomac Hospital.

HIC#	SURNAME*	DATE OF DEATH
[redacted]	[redacted]	3-16-86

I hope this information helps strengthen your data base.

Sincerely,

Gregory C. Wood
Vice President

GCW:nmp
Wang #6508I

2300 Opitz Boulevard, Woodbridge, Virginia 22191 (703) 670-1313

PRINCE WILLIAM HOSPITAL

Our Pride Is In A Healthy Community.

E.L. Derring
Administrator

8700 SUDLEY ROAD
P.O. BOX 2610
MANASSAS, VIRGINIA 22110-9879
703 369-8350

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Doctor Roper:

We have carefully reviewed the specific mortality data for Prince William Hospital from the Health Care Financing Administration and would like to share the following with you:

1) Prince William Hospital is a not-for-profit community hospital that provides acute care beds for medical/surgical patients. The hospital has an Oncology Unit as well as a Psychiatric Unit and an Alcohol/Drug Abuse Rehabilitation Unit.

2) We found the statistics you gave us showed 901 medicare admissions. Our records indicate there were 1,556 medicare admissions. Of these, 223 patients were under the age of 65 and had medicare coverage due to a chronic illness.

3) HCFA figures showed 28 patients died after discharge from the hospital. Our figures indicate that 27 patients died after discharge. One patient was readmitted and died on a subsequent admission.

Of the 27 patients who did die after discharge from the hospital, there was assistance from our hospital Social Service Department in 26 cases. The patients either were returned to a

nursing home bed, were a new admission to a nursing home, went home with home health services, to in-patient hospice, in-home hospice or transferred to another hospital. In one case, the family refused any post-discharge assistance in the care of the patient at home.

The average age of these patients was 78 years.

4) Prince William Hospital received a 3 year accreditation from the Joint Commission on Accreditation of Hospitals in 1987. The hospital has an active Quality Assurance Committee of the Medical Staff and the Hospital that monitors all patient care. We are aware of the mortality statistics of our hospital and recognize these statistics as just one of many factors that are an indicator of the quality of care given at this hospital.

Sincerely,

Kenneth B. Swenson
Senior Vice President/Operations

S. Marc Krenyzky, M.D.
Chairman
Utilization Review Committee

Radford
The Community Hospital

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

RE: Medicare Provider #49-0042

Dear Sir/Madam:

We continue to be concerned about the measurement of quality by using mortality data. As acknowledged by Dr. Willam Roper in a letter dated September 21, 1987, the information contained in the HCFA report "on its own is not a complete measure of quality of care at an individual hospital". To accurately assess hospital performance which is dependent upon many variables, a number of quality indicators must be evaluated. Mortality rates are but one of these quality indicators.

Quality care is of utmost concern to the board members, management, medical staff, and employees at Radford Community Hospital. Our quality assurance program is an ongoing, objective and systematic evaluation process to evaluate the quality and appropriateness of patient care. Through this process, opportunities are identified to improve patient care and take action to resolve problems and follow-up to assure resolution. The committee is composed of a physician chairman, five physician members, one quality assurance coordinator, one nurse, and three administrative staff members.

In reviewing the mortality data and comparing the information with patient records, the following discrepancies were noted:

Patient ID #/Name	Description of Error	Per Report	Per Records
[redacted]	Diagnosis	4101	1281
	Date of Death	1/8/86	1/7/86
	Date of Death	12/20/86	5/87*
	Date of Death	3/30/86	'87*
	Admission	11/1/86	10/15/86

P.O. Box 3527 ● Radford, Virginia 24143 ● (703) 731-2000
Eighth and Randolph Streets

Patient ID#/Name	Description of Error	Per Report	Per Records
[redacted]	Diagnosis	1623	4310
	Diagnosis	4280	4279

*Seen in the doctor's office

The following deaths could not be confirmed:

[redacted]	6/19/86
	10/9/86
	5/28/86
	12/27/86

It may be helpful to note that the case mix index for 1986 for Radford Community Hospital was 1.1161 which represents a fairly intense level of services for an acute rural hospital. As a comparison, the case mix indices of the two closest neighboring hospitals of similar size was 1.0663 and .9716 for the same period.

Cardiology services at Radford Community Hospital offers a comprehensive range of programs and procedures to residents in a broad geographic area of southwestern Virginia. Though the mortality rate is within the predicted ranges for severe chronic heart disease and severe acute heart disease, the upper mid-range rate reflects the treatment of these types of patients and the higher intensity of services they require.

A significant limitation of the HCFA anaylsis is that the various intensities or levels of care and services within a given diagnostic category is not taken into consideration. An example would be a hospital with a regional cardiac program which may have a high mortality rate in the diagnostic categories for heart disease.

In closing, Radford Community Hospital is a 175-bed not-for-profit hospital governed by a voluntary board. As a result of the comprehensive services provided and the diversity of the medical staff (61 active staff representing 22 speciality areas), the hospital has established a regional presence, drawing patients from a 50-60 mile radius in rural southwestern Virginia.

Sincerely,

William E. Merkt

William E. Merkt, executive vice president and
chief operations officer

WM/bh

HCA Reston Hospital Center

Provider # 490170

COMMENTS ON THE HCFA MORTALITY DATA
RESTON HOSPITAL CENTER, RESTON, VIRGINIA

Interpretive Remarks

In response to the HCFA mortality data concerning Medicare patients, we make the following comments:

1. The data is listed under the name of Reston Medical Center. The name of this institution is Reston Hospital Center.

2. Reston Hospital Center did not open until November 11, 1986. Only three of the patients listed in this data were treated at Reston Hospital Center. The remaining patients listed were treated at Circle Terrace Hospital in Alexandria, Virginia, which is no longer operational. The data generated by Circle Terrace Hospital greatly differs from that of Reston Hospital Center for the following reasons:

   a. Geographic location - Circle Terrace Hospital was located in Alexandria, Virginia, while Reston Hospital Center is located is western Fairfax County.

   b. Case mix - The percentage of Medicare patients at Circle Terrace Hospital was greater than at Reston Hospital Center.

   c. Medical Staff - The Medical Staff of Circle Terrace Hospital did not transfer to Reston Hospital Center. A new Medical Staff was formed.

   d. Services - Circle Terrace Hospital did not have an emergency services department as does Reston Hospital Center.

   Therefore, this data should be credited to Circle Terrace Hospital not Reston Hospital Center.

3. The issue of small sample must be addressed, since this can greatly skew the data. In some of the categories listed for Circle Terrace Hospital, the sample size is ten (10) or less. Valid statisical conclusions can not be derived from samples of this size.

Contact person: Judith M. Riggins
703-689-9040

1850 Town Center Parkway
Reston, Virginia 22090
Telephone (703) 689-9000
A subsidiary of HCA The Healthcare Company

Hospital = 490071



October 28, 1987

Dear Health Care Consumer:

The following information for The Retreat Hospital is to be included with its specific report for 1986.

The Retreat Hospital is a 230 bed, acute care community facility providing quality care in numerous medical and surgical specialty areas such as cardiology, pulmonology, orthopedics, colo-rectal endoscopy and ophthalmology. The Immediate Care Center provides the community with quality assessment and treatment of health care emergencies on a 24 hour basis.

As a not-for-profit hospital since 1877, Retreat has a long tradition of delivering quality care in a cost conscious manner. We have an excellent reputation for care and caring among those we have served.

Retreat Hospital established a specialty unit of nurses trained in the care of cancer patients as well as a hospice program which offers patients and their families the special support needed in living with dignity when death is imminent. The hospital plays an active role in referral arrangements with physicians and other hospitals for these specialty patients and we believe many patients come here not only for quality care in healing, but for quality caring in dying.

The HCFA data displayed in this report are as accurate as the current method of reporting permits, but it is not all inclusive. While it is extremely difficult to measure quality, better methods of evaluation are continually being investigated by the American Hospital Association and the Joint Commission on the Accreditation of Hospitals.

Quality of care is of the utmost concern to The Retreat Hospital's governing board, management and medical staff. Any indication of

potential quality problems leads to a prompt investigation through our quality assurance program to determine if a problem, in fact, exists. If a quality problem is identified, corrective action is immediately taken.

Thank you for the opportunity to append this statement to our data.

Sincerely,

W. M. Loving, Jr.
Chief Executive Officer

RICHMOND MEMORIAL HOSPITAL

We Care for Life.

Richmond Memorial Hospital (Richmond, Virginia) is pleased to have this opportunity to respond to the HCFA Mortality Information for 1986.

These mortality rates are calculated for Medicare patients only a patient population by definition, generally 65 years of age or older. In calculating these mortality rates, HCFA has included patients who died in the hospital, as well as those who died within 30 days of a hospital admission. This means the mortality rate includes patients who died in a nursing home, hospice or at home. When these patients are not included in the calculations, the mortality rate at the hospital is substantively lower.

Richmond Memorial Hospital supports the continuing efforts to define the patient's severity of illness so that future mortality statistics will more closely approximate the true quality of care received by the patient.

In these statistics, a number of medical conditions, i.e. diagnoses, were grouped together to form a category for which one mortality rate is reported. This combination of several diagnoses makes it difficult for the public to analyze the data without further information.

For further clarification, Richmond Memorial Hospital has provided some additional information on several of our large categories.

Overall, Richmond Memorial Hospital had 2,936 Medicare cases with a mortality rate calculated at 12%. The range of mortality rates predicted by HCFA for this hospital is 8-15%.

In one large category, gastrointestinal disease, there were 20 deaths of 292 patients treated. Of the 20 deaths, 55% of them were over age 75 and 15% had cancer along with the disease, which led to their death. Also 40% had cardiac problems, 40% had respiratory problems and 65% had other problems such a diabetes or renal failure.

In other large volume categories, the trend toward a high average age and several pre-existing medical conditions continues to be noted. Of the 44 patients who died of low risk heart disease or severe chronic heart disease at Richmond Memorial, 31 (or 70%) were over age 75 years. For pulmonary diseases, 78% (31/50) of the patients who died were over age 75.

1300 Westwood Avenue • Richmond Virginia 23227 • (804) 254-6000

Of the 54 cancer deaths, 55% of the patients had cancer in a secondary site. Also, 28% had cardiac conditions, 20% had respiratory diseases and 33% had other problems such as diabetes, sepsis or renal failure. 26% of these patients (14 of 54) died after being discharged from the hospital, either in a nursing home (2 patients) or at home (12 patients).

Of the 44 deaths attributed to cerebrovascular accidents, 5% of the patients had cancer along with the cerebrovascular accident which led to their death, 50% had cardiac conditions, 9% had respiratory diseases and 14% had other illnesses such as diabetes or renal failure. In terms of age, 68% (30 of 44) were over age 75 and 57% (25 of 44) were 80 years or older.

Please direct any questions regarding these figures or the mortality statistics to the Public Relations Office.

Richmond Memorial Hospital (490069)

RIVERSIDE HOSPITAL

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Balitmore, MD 21207

RE: Provider Number 490052

Gentlemen:

After reviewing the information you have compiled on Riverside Hospital's 1986 Medicare mortality rates, we would like to make the following comments.

While Riverside Hospital's death rates are within the predicted range overall and for all sixteen (16) diagnostic categories, the model used to predict our rates fails to fully recognize the acuity level of patients admitted to our facility. As the only teaching hospital and the largest hospital in our primary service area, Riverside provides the most technologically advanced services available. For instance, in 1986, Riverside Hospital was the only provider between Richmond, Virginia and Norfolk, Virginia to have an inpatient hospice program; a cancer treatment center; a cardiac catherization laboratory; an open heart surgery program; and a nursing unit dedicated to the treatment of patients recovering from neurosurgery. By offering these services, Riverside serves as a regional referral center for patients suffering from all forms of cancer, heart disease, and neurological disorders. By not recognizing the impact of these programs on our patient mix and severity of illness, the model used by the Health Care Financing Administration most likely has under-estimated the ranges within which our death rates should fall.

As an institution, Riverside Hospital always has had a strong commitment to providing the highest quality service possible. In an effort to insure on an ongoing basis that we meet this challenge, numerous quality assurance mechanisms have been instituted. While many of these, such as death review, blood and

tissue review, and the ongoing monitoring of key clinical indicators for the various hospital departments, are required for maintenance of Joint Commission accreditation, our quality assurance activities far exceed these requirements. For example, the hospital is accredited by the American College of Surgeons for meeting the requirements of a Community Hospital Comprehensive Cancer Program and by the Commonwealth of Virginia as a Level II Trauma Center. Maintenance of each of these designations requires intensive, ongoing review of the care provided to cancer patients and trauma victims. As previously mentioned, the hospital serves as a residency site for family practice and OB/GYN residents. As such, there are numerous ongoing quality assurance and educational activities aimed at not only insuring and increasing the knowledge and competency of our residents, but also our entire medical staff.

In summary, Riverside Hospital is pleased that its mortality rates for 1986 fall within the predicted range and is confident that the care provided to all of its patients is of the utmost quality. We recognize that it is difficult for the predictive model used to encompass all factors influencing the quality of care, but also believe the deficiencies cited earlier may have resulted in our predicted mortality rates being understated.

Thank you for the opportunity to provide these comments.

Sincerely,

Gerald R. Brink
President

GRB:ph

Roanoke Memorial Hospitals

Belleview at Jefferson Street
Roanoke, Virginia 24033

October 27, 1987

William L. Roper, Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Mr. Roper:

Thank you for the opportunity to respond to the Mortality Report compiled by Health Care Financing Administration relative to Roanoke Memorial Hospitals' 1986 Medicare patients.

Forty-six of the cases reported as Roanoke Memorial Hospitals' patients were, in fact, not hospitalized here during 1986. Analysis also shows that the average age of the patients included in this study was 77.7 years -- high death rates in this age group are not unexpected. Finally, almost half of the patients reported were from outside the Roanoke area. This indicates a significant number of patients were referred or transferred to this hospital because they required its specialized facilities and services. These patients tended to be more acutely ill, and a higher death rate would be expected.

The diagnosis groupings used in the analysis were categories where illnesses were more severe and where death could more reasonably be expected. This had the effect of pushing mortality rates upward and was not balanced by including groupings where severity of illness was low. Using only a sample of the total number of Medicare patients that were hospitalized instead of the entire population of Medicare patients skews mortality rates upward.

Another significant concern is the lack of a severity of illness index. Incorporating such an index into the evaluation of data would help reconcile differences between hospitals that treat more acutely ill patients and hospitals that treat less intensively ill patients.

An additional concern is that the report included not only patients that expired while in the hospital but also patients who died within 30 days of discharge. No study was made to determine whether death was caused by the same disease or illness that caused hospitalization or by another cause such as an accident or an unrelated illness.

It is our hope that consideration will be given to improving the validity of data released to the public in order that individual citizens may make more informed decisions about the health care provided in their community. Again, we appreciate the opportunity to respond to this study.

Sincerely,

Houston L. Bell, Jr.
Chief Operating Officer



Southside Community Hospital

October 21, 1987

Dr. William L. Roper
Administrator
Health Care Financing Administration
Department of Health and Human Services
Hubert H. Humphrey Building
Room 309-G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Roper:

We recently received the report from the Health Care Financing Administration that included the mortality rates for Southside Community Hospital. While the mortality figures are helpful in defining the quality of health care offered at our institution, this statistic is only one small piece of the puzzle. It is unfortunate that the publication of this data has resulted in very distorted and, therefore, severely damaging images of high quality health care facilities before the general public.

In the case of the report for Southside Community Hospital, the report lists six patients that were transferred to other hospitals. Since this is a primary care facility, these patients were transferred quickly to other facilities for definitive care. Regardless of what was done at these other facilities, the statistic ends up as a black mark against this hospital. Ten of the patients were transferred to nursing homes and, again, the hospital's standing on this report becomes dependent on the care offered in these other institutions.

In conclusion, although valuable when used in proper perspective, the mortality report should not be used as a benchmark standard to define the quality of care provided by acute care hospitals. The report has inherent faults that weakens its validity as mentioned above. Its distribution should be directed to local Peer Review Organizations for inclusion in their quality assessment activities rather than issued as a stand alone report.

800 Oak Street • Farmville, Virginia 23901-1199 • (804) 392-8811

Please do not hesitate to contact me should you have any questions regarding this report.

Yours truly,

Thomas J. Rice III
Administrator

TJR/lhh

Southside Regional
MEDICAL
CENTER

801 South Adams Street
Petersburg, Virginia 23803
804/862-5000

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

This is to acknowledge receipt of the HCFA mortality information for Southside Regional Medical Center. We did not receive the original mailing. However, following an inquiry to your office, we did receive the information via express mail on October 6, 1987. After reviewing the information we would like to submit the following comments:

Data Verification

The data used by HCFA indicate that in 1986 a total of 283 Medicare patients admitted to Southside Regional Medical Center died within 30 days of admission. Of these, 250 died while still in the hospital, and 33 died after discharge. Hospital records indicate that 4,176 Medicare admissions occurred in 1986, while HFCA data indicate 2,289 admissions. The difference reflects multiple admissions of individual beneficiaries and transfers to other hospitals. We have no way of verifying whether the HCFA number of Medicare patients treated is correct. Our records also indicate that of the 283 Medicare patients who died within 30 days of admission, 33 were still alive when discharged. It is impossible to verify whether the 33 patients who died after discharge from our facility died within 30 days of admission, since such information is not included in the patients' medical records.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

A detailed review of the HCFA data confirmed that the hospital's actual mortality rates fall within all predicted ranges for mortality. Even though all outcomes are within the expected limits, Southside Regional Medical Center has focused further attention on the report through our medical staff Quality Assurance Program. The purpose of this effort is to ensure the quality of care at the hospital. Should a problem be identified, then immediate corrective action will be taken.

The preliminary quality assurance studies we have conducted indicate several important factors which were not included in the HCFA analysis. First, some of the cases revealed that death was likely or the patient was terminally ill prior to hospital admission. Secondly, some cases involved other diseases which significantly affected the patients' conditions or contributed to death. Including these data may have caused HCFA's predicted mortality ranges to be higher than are shown. Finally, in some cases the actual cause of death was found to be different than what was listed in the HCFA data. This is because of HCFA reporting requirements and may have caused some categories to appear differently than they actually should have been.

As stated previously, the hospital will continue with additional quality assurance studies to assure the delivery of quality patient care.

Sincerely,

Peter C. Olden
Associate Director

PCO/hc

ST. MARY'S HOSPITAL
A Bon Secours Health Care Facility

October 20, 1987

The Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

RE: COMMENTS ON THE HCFA MORTALITY DATA
St. Mary's Hospital, Richmond, VA
Medicare Provider Number - 490059

The data used by the Health Care Financing Administration indicate that for the period January through December 1986, a total of 271 Medicare patients admitted to St. Mary's Hospital died within 30 days of admission. Of these, 228 died while still a patient of the hospital, while 43 died after discharge. In all diagnostic categories, St. Mary's actual mortality rate falls within the range of HCFA's predicted mortality rate.

St. Mary's has carefully reviewed the HCFA information and is in basic agreement with the HCFA statistics. We are concerned, however, that the data, wrongly interpreted, could lead to some misleading assumptions.

St. Mary's Hospital, owned and operated by the Sisters of Bon Secours, adheres to a humanistic approach to patient care and involvement of patient and family when quality of life issues are concerned. In addition, it is the Hospital's policy and philosophy that a patient's length of stay should be determined by the physician, not by reimbursement.

Furthermore, St. Mary's is a designated Cancer Center, recently receiving a three-year approval from the Commission on Cancer of the American College of Surgeons. Its Hospice Program has been accredited by the Joint Commission on the Accreditation of Hospitals. Both programs treat extremely ill patients. Death, in many cases, is the expected outcome.

It should be noted that the 42% actual mortality rate for diagnostic category SE (sepsis) involved patients whose deaths were imminent. All 16 patients were severely ill having "no resuscitation" orders requested by next-of-kin.

In diagnostic category EY (ophthalmologic disease), an actual mortality rate of 11% was reported. It should be noted that the one case involved a patient admitted with the diagnosis of intractable eye pain. The patient,

a 78-year-old woman with a history of diabetes, organic heart disease, and other medical problems, died of congestive heart failure.

Finally, in diagnostic category OP (orthopaedic disorders), the actual mortality rate of 1% could be easily misinterpreted. The patient, although admitted for an orthopaedic injury to the chest, died of heart failure. The patient had previously suffered a heart attack in addition to having diabetes and other medical problems unrelated to the reason for admission.

Thank you for including our comments in the HCFA report on mortality data.

Christopher M. Carney
Executive Vice President

CMC:nls

The Fauquier Hospital, Inc.
500 Hospital Drive Warrenton, Virginia 22186
(703) 347-2550

WILLIAM D. DOELLER
PRESIDENT
ROBIN C. GULICK
VICE-PRESIDENT
DAVID C. GERRISH, JR.
SECRETARY-TREASURER
WILLIAM H. GREEN, JR.
ADMINISTRATOR

October 26, 1987

Health CAre Financing Administration
Health Standards Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21107

RE: HCFA Mortality Data
Medicare Provider # 490023

Dear Sirs:

Fauquier Hospital has reviewed the mortality information sent by HCFA September 21, 1987. The data sent by HCFA indicate that a total of 111 Medicare patients admitted to Fauquier Hospital died within 30 days of admission during 1986. The information provided by HCFA indicates that 86 patients died while still a patient of the hospital, while 25 died after discharge. Our records indicate that 91 died while still patients and 20 died after discharge the corrections are attached to this letter. Of the 20 patients who died after discharge we were only able to verify 5 of the deaths. Thus 15 are unverified since information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Sincerely,

Rodger H. Baker
Acting Administrator

RHB:sf
Enc.

FAUQUIER HOSPITAL

WARRENTON, VIRGINIA

ID 4900 23
MORTALITY DATA CORRECTION

PATIENT ID NUMBER (MIC)	DATE OF DEATH PER HCFA	DATE OF DEATH PER MEDICAL RECORD
[redacted]	11/10/86	11/19/86
[redacted]	02/03/86	02/01/86
[redacted]	05/19/86	05/15/86
[redacted]	10/31/86	10/14/86

	DATE OF ADMISSION PER HCFA	DATE OF ADMISSION PER MEDICAL RECORD
[redacted]	12/12/86	12/26/86

	DATE OF DISCHARGE PER HCFA	DATE OF DISCHARGE PER MEDICAL RECORD
[redacted]	12/21/86	1/8/86

UNIVERSITY OF VIRGINIA HOSPITALS
CHARLOTTESVILLE, VIRGINIA 22908
(804) 924-2258

OFFICE OF THE EXECUTIVE DIRECTOR

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
6300 Security Blvd.
Room 2D2, Meadows East Bldg.
Baltimore, Maryland 21207

Dear Dr. Roper:

We appreciate the opportunity to review the mortality information related to Medicare patients as prepared by your agency for the University of Virginia Hospitals (Medicare Provider No. 490009). The University of Virginia Hospitals (UVAH) continually reviews patient mortalities as part of our comprehensive quality assurance program. We find that the draft data which you submitted differs significantly from our records. While there were slight discrepancies in most of the diagnostic categories, we limit the illustration of differences to the most material variances.

There is wide discrepancy between the total number of Medicare cases reported. The HCFA analysis shows 3,596 cases while our records indicate that over 6,350 Medicare patients were admitted to our hospital in 1986, or a difference of over 2,750 cases. In addition the individual list of patients who died included five cases with admission dates in 1985. The HCFA report shows a mortality rate of 10% for all cases while our data indicates that the overall Medicare mortality rate is 6%. Obviously, the difference in cases reported accounts for some of the error. By comparing the 6,350 cases for 1986 to the number of cases reported in the Hospitals' cost report for 1986-87 of 6,232, we can establish the reasonableness of the Hospitals' data.

In addition to the variance in total cases we wish to note certain specific diagnostic categories which show rates well above those contained in our records:

	Calculated Mortality Rates		Difference of UVAH Cases Less HCFA Cases
	HCFA	UVAH	
Severe Acute Heart Disease	40%	11%	+76
Metabolic/Electrolyte Disturbances	22%	16%	+31
Pulmonary Disease	19%	10%	+192
All Other Conditions	10%	3%	+1079

We understand your interest in publishing the Medicare Mortality rate data in December 1987. However, we have serious concerns related to the accuracy of the report. We would be pleased to work with a representative of your agency in correcting the information concerning the University of Virginia Hospitals. The University of Virginia Medical Center's faculty, staff and students share your interest and concern for maintaining the delivery of quality patient care to all citizens.

Sincerely,

John T. Ashley, M.D.
Executive Director

JTA/dhs

cc: Virginia Hospital Association
Dr. William H. Muller, Jr.

Centra Health, Inc.
P.O. Box 3004, Lynchburg, VA 24503
(804) 528-1177

October 16, 1987

William L. Rober, M.D., Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Sir:

A preliminary review of the data submitted by the Health Care Financing Administration as regards this Hospital's Medicare beneficiary mortality statistics (Virginia Baptist Hospital; number 490021), revealed the following errors:

		Incorrect Data
Patient I.D.	[redacted]	
Surname		
Diagnostic Category	HL	UN
Age/Sex	85/Male	
Admit Date	12/30	12/17
Discharge Date	1/02/87	12/23/86
Date of Death	1/02/87	
Principal Diagnosis	424.1	995.2
Principal Procedure	38.93	

(Hospital records show the last 1986 admission to be 12/30/86, not 12/17/87 as reported).

		Incorrect Data
Patient I.D.	[redacted]	
Surname		
Diagnostic Category		PN
Age/Sex	74/Male	
Admit Date	7/08	
Discharge Date	7/09	
Date of Death		
Principal Diagnosis	486.1	
Prinicipal Prodedure		

Note: Hospital records do not show that this patient was ever admitted to Virginia Baptist Hospital).

Thus, the number of cases listed for "All Causes should be adjusted to 1,803; number of cases listed for diagnostic category

"HL" (Low-risk Heart Disease) should read 131; and, for diagnostic category "UN" (All Other Conditions), 30. The number of cases listed for diagnostic category "PN" (Pulmonary Disease) should be adjusted to 18; "Actual Mortality Rates" must also be adjusted accordingly.

Thank you for your consideration in acknowledging these errors. If I can be of further assistance, please contact me at (804) 528-1177.

Sincerely,

Michael A. Barger
Treasurer

MAB/vad

cc: T. C. Jividen, President, VBH

VIRGINIA BEACH GENERAL HOSPITAL

October 22, 1987

Health Care Financing Administration
Department of Health & Human Services
Attention: HSQ-148-GNC
P.O. Box 26676
Baltimore, Md 21201

Dear Sirs:

Thank you for opportunity to review and comment on our 1986 mortality information. After reviewing the data we have prepared the following comments which we hope you will consider in preparation for the 1987 mortality information release.

Report Format

The hospital data table should include the "All other Conditions" category with corresponding cases and rates. The sum of the cases should equal the total number of cases in the "All Causes" category.

It would also be helpful to include the total number of cases for each diagnostic category along with the actual mortality rates.

Methodology

Although we found some discrepancies with the reported deaths they were minor in nature and would not affect the reported results. Consideration should be given to reporting only hospital deaths and not deaths that occur 30 days after admission. Once a patient is discharged from the hospital he could expire from a number of causes not necessarily related to the reason the patient was in the hospital. We do feel that the methodology should make adjustments for severity-of-illness.

Interpretation

Although HCFA and hospital organizations warned not to use the data to compare local area hospitals, the probability of the media doing so is quite high. The potential harm a hospital could suffer due to such a comparison is quite real. We trust that when HCFA releases this information they will make every effort to dissuade the idea of ranking area hospitals by their reported mortality rates.

Thank you for your attention. We hope our comments will be of benefit to you for future releases.

Sincerely,



DOUGLAS L. JOHNSON, Ph.D.
President and CEO
Tidewater Health Care, Inc.

WARREN MEMORIAL HOSPITAL

1000 Shenandoah Avenue
Front Royal, Virginia 22630
703-636-0300

October 27, 1987

Dr. William L. Roper, Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper,

Internal mortality statistics at Warren Memorial Hospital do not correspond with the HCFA statistics received. The HCFA methodology is vague, and we are unable to replicate the numbers. The internal review at our facility revealed that 7 in-hospital deaths occurred during the 1986 time frame that were not listed in the statistics by HCFA. However, the HCFA did list 21 patients that died outside our facility, including those whose death occurred in other acute care institutions.

According to HCFA statistics, patients who die within 30 days of their last admission to Warren Memorial were listed as mortalities for our hospital. This information is very misleading. Some of these patients had been discharged to home and were readmitted to another hospital within that 30 day time-frame. Other patients were discharged and transferred to other institutions such as acute care hospitals, skilled nursing facilities, intermediate care facilities, or rest homes. Some patients included in the statistics also died with disease processes other than those listed by HCFA. I feel your information is not a true instrument for measuring quality of care at any institution.

The level of care provided by our facility is not related to the mortality rates. The mortality statistics of our hospital should include those patients whose death occurred within our facility and not those whose death occurred elsewhere.

Quality of care cannot be addressed or determined by looking at HCFA's mortality statistics. Numerous factors (admitting diagnosis, pre-existing conditions, age of the patient, etc.) must be included in evaluating the overall quality of care for all patients, not just mortalities.

Sincerely,

C. Douglas Rosen

C. Douglas Rosen
Administrator

cc: W. Houston Board III
Chairman of the Board of Trustees
Wayne Seipel, M.D.
President,
Medical Staff

Taking a Healthy Interest In You.

WILLIAMSBURG
Community Hospital

1238 Mount Vernon Avenue • Williamsburg, Virginia 23185-9988 • (804) 253-6000

26 October 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administrator
Health Standards & Quality Bureau
P.O. Box 26684
Baltimore, Maryland 21207

Re: HCFA 1987 Mortality Rate Release
Williamsburg Community Hospital Response 490066

Dear Sir:

I am commenting regarding the Mortality Rate Release information supplied to us 21 September 1987.

Data Validity:

The date used by HCFA indicate that a total of 97 Medicare patients admitted to Williamsburg Community Hospital died within 30 days of admission. Of these, 76 died while still an inpatient of the hospital, and 21 died after discharge. Our own internal review of the data supports the general accuracy o the inpatient statistics except in two cases (which involve incorrect date of death); however, it is impossible to verify the percentage of the 21 patients who were listed as dying after discharge, as information concerning death after discharge is not retrospectively included in the patient's medical record.

Continuity of care is of prime importance in the healthcare field. Forty-three percent of those 21 deaths were dicharged to other short-term hospitals, nursing homes and other facilities to receive on-going care. The rest were discharged home. One can only presume death occurred at the location to which the patient was discharged.

In all of the 16 HCFA diagnostic categories Williamsburg Community Hospital never exceeded the range of predicted mortality rates. In 5 of the 16 we are at or below the lower range of the predicted rates.

General Comments:

In analyzing the HCFA data one must consider several factors.

1. It is the goal of physicians and health care personnel within hospitals to provide quality care and abide by the wishes of the patient and family. In some instances patients refuse recommended life-saving treatments. Hospitals that serve a sizeable population of geriatric patients will often encounter patients with long-standing degenerative and debilitating conditions such as COPD, emphysema as well as terminal illnesses such as some cancers. Sometimes medical management becomes ineffective or the patients request to have aggressive treatment discontinued to allow death in the hospital or home.

2. The majority of these patients also exhibit diseases and disorders that affect several body systems and can develop unforeseen medical complications.

3. The waiting list that exist for placement into nursing homes can also affect the hospital mortality rate. Patients with chronic and terminal illnesses that need such placement may die in the hospital awaiting placement to an intermediate or skilled facility.

4. Finally, the HCFA model measures a relationship between limited number of patient characteristics (age, sex, diagnosis, etc) and the risk of death but cannot reliably predict hospital mortality rates. The HCFA system fails to consider other patient factors such as the severity or stage of a patient's illness. Administrative officials within HCFA also agree that mortality rates cannot be used as a sole indcator of hospital performance. Quality judgments regarding patient care can only be made after careful review of the patient's medical record. All deaths within our hospital are reviewed by a committee of physicians thereby ensuring an on-going assessment of physician and hospital performance in delivering the best care possible.

CORRECTIONS TO HCFA MORALITY DATA - 1987

Date of death was incorrect on the two cases listed below:

Pg	Patient I.D.	Surname	Diag. Cat.	Date of Admission	Date of Discharge	Date of Death
2	[redacted]	[redacted]	SE	12/05/86	12/18/86	12/18/86
2	[redacted]	[redacted]	UN	04/15/86	04/16/86	04/16/86

Thank you for giving us the opportunity to respond to your findings.

Sincerely,

Stephen H. Montgomery
Senior Vice President

/sjh

Winchester Medical Center, Inc.
A Subsidiary of Winchester Regional Health Systems, Inc.

Office of Administration Phone (703) 665-5115

Medicare provider number - 490005

October 27, 1987

Winchester Medical Center is a regional referral center serving the tri-state area of Virginia, Maryland, and West Virginia. The Medical Center is committed to providing the highest quality of care to its patients. Quality care is of the utmost concern to the Medical Center's governing board, management and medical staff. Any indication of potential quality problems, including a mortality rate that is higher or lower than predicted, leads to a prompt investigation to determine if a problem, in fact, exists. When quality problems are identified, corrective action is swiftly taken.

The HCFA mortality data should be used principally by hospitals to identify or suggest areas for review. The mortality data do not identify areas in which the Medical Center provides "high quality" or "low quality" care or otherwise measure hospital performance. A mortality rate higher than predicted does not confirm the existence of quality problems, just as a mortality rate lower than predicted does not establish that the Medical Center provides "high quality" care. Actual mortality rates can be higher or lower than predicted because the patients treated by the Medical Center differ from the patients treated in

201 S. Stewart St. PO Box 3340 Winchester, Virginia 22601-2540
THE APPLE CAPITAL

the "average" hospital, or because the care provided differs from the care provided in the "average" hospital, or simply because of chance. Comparisons of actual and predicted mortality rates can only suggest that the Medical Center and its medical staff review an area to determine if a quality problem does exist or if the patients treated by the Medical Center are simply unusually complex or have other characteristics not recognized by the HCFA model that would lead to an above average mortality rate.

The ability of the HCFA model to detect differences in quality has never been evaluated. The HCFA data assumes that each hospital's patients are "average" except with respect to the few characteristics included in the statistical model. The model does not include measures of severity (i.e., how ill was the patient at the time of admission), whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness, or the patient's psychological state or general health status. As a result, hospitals treating unusually large numbers of severely ill patients (e.g., referral hospitals) or with specialized programs for the terminally ill may have higher than predicted mortality rates.

The HCFA data are not all-inclusive. The mortality rates apply only to Medicare patients, and differ from other indicators of inpatient mortality because they are calculated using only deaths that occurred within 30 days of the last admission of a Medicare beneficiary to a hospital during 1986.

The American Hospital Association and other organizations, including the Joint Commission, are investigating methods of evaluating hospital quality that rely on measures other than mortality rates. Winchester Medical Center looks forward to the results of these efforts as better measures of quality are needed for public review.

Wythe County Community Hospital

"Wythe Caring Comes Healing"

600 WEST RIDGE ROAD
WYTHEVILLE, VIRGINIA 24382
(703) 228-2181

September 29, 1987

The Healthcare Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O.Box 26684
Baltimore, Maryland 21207

TO WHOM IT MAY CONCERN:

We have had the opportunity to review the information sent to us regarding the Mortality Report which will be published to the nation during the month of December. Our review indicates several errors in the information provided to us. Not the least of which, is the fact that a large number of patients were not included in the listing provided to us that in fact did pass away while hospitalized at Wythe County Community Hospital. In addition, we found numerous errors in the actual data presented to us regarding the expiration dates of those patients listed by the Healthcare Financing Administration. Our concern arises from the fact that the validity and accuracy of this data appear to be in question. Additionally, statements by Dr. Roper himself in a letter dated September 21, 1987 recognize the limitations of this data in providing meaningful information to the public. The question I would raise at this point is: With obvious discrepancies in the accuracy of the information generated and the questionable validity and value of the information, why then is it necessary to publish this information for the American public? In our opinion, it is neither valuable nor necessary and can only provide confusion to an American public that deserves better and more accurate information than they are being provided.

Sincerely,

Scott K. Adams

Scott K. Adams,
Administrator

SKA/std

Washington

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
AUBURN GENERAL HOSPITAL AUBURN WA 98002	WA-11	1101	15	9-16	87	16	13-33	21	14	11-48	37	22	7-34	73	25	14-33	71	45	27-50	30	20	6-36	125	26	13-29
BALLARD COMMUNITY HOSPITAL SEATTLE WA 98107	WA-12	1393	14	9-16	125	25	13-31	53	38	19-44	21	19	7-42	76	30	17-37	50	52	24-52	16	0	3-42	127	26	13-29
BLACK HILLS COMMUNITY HOSP OLYMPIA WA 98502	WA-13 *	413	17	10-19	36	61	22-54	13	31	12-59	17	18	9-50	9	33	5-57	18	44	22-65	5	20	1-69	43	26	9-33
CASCADE GENERAL HOSPITAL LEAVENWORTH WA 98826	WA-14 *	138	12	7-19	5	80	6-75	11	27	14-66	3	0	2-82	3	0	2-81	4	50	7-82	2	0	0-96	6	33	2-64
CASCADE VALLEY HOSPITAL ARLINGTON WA 98223	WA-15	343	16	9-18	12	8	5-50	14	36	11-56	12	17	4-49	24	25	11-45	23	61	21-60	8	25	2-57	33	15	9-38
CENTRAL WASHINGTON HEALTH WENATCHEE WA 98801	WA-16 *	2018	11	7-14	209	25	15-31	56	29	17-41	46	15	7-31	66	24	14-35	78	36	25-47	50	10	8-32	148	20	13-29
CENTRALIA GENERAL HOSPITAL CENTRALIA WA 98531	WA-17 *	829	13	9-16	51	18	10-35	22	45	13-50	22	14	5-39	54	19	15-38	40	55	26-57	27	33	12-46	62	24	14-36
COLUMBIA BASIN HOSPITAL EPHRATA WA 98823	WA-18 *	92	25	10-26	3	100	4-84	3	33	6-87	2	0	0-90	11	55	10-60	12	33	13-63	1	0	0-98	7	29	4-62
COMMUNITY MEMORIAL HOSPITA ENUMCLAW WA 98022	WA-19 *	304	14	9-18	15	40	14-60	14	29	11-56	10	10	3-51	25	32	11-44	11	36	17-71	7	29	4-63	40	18	8-33
COULEE COMMUNITY HOSPITAL GRAND COULEE WA 99133	WA-20 *	45	9	4-25	2	50	1-89	1	0	0-97	1	0	0-99	4	25	2-75	.	.		2	0	0-90	9	22	5-57
DAYTON GENERAL HOSPITAL DAYTON WA 99328	WA-21 *	91	10	9-25	6	33	12-78	5	0	5-73	2	50	1-89	.	.		6	17	14-80	1	0	3-100	14	21	5-47
DEACONESS HOSPITAL SPOKANE WA 99210	WA-22	2857	8	9-15	233	18	18-34	57	30	17-41	54	13	9-32	122	24	17-33	170	19	29-46	22	14	6-41	208	15	13-27
DEER PARK HEALTH CENTER HO DEER PARK WA 99006	WA-23 *	120	7	8-22	3	33	4-85	1	0	1-97	7	0	4-63	3	0	2-81	1	0	1-97	4	25	7-82	29	3	9-40
EVERGREEN HOSPITAL MEDICAL KIRKLAND WA 98033	WA-24	1071	14	9-16	91	24	16-37	41	32	15-43	43	12	7-32	59	22	14-37	49	41	26-53	22	23	8-44	77	22	14-34
FERRY COUNTY MEMORIAL HOSP REPUBLIC WA 99166	WA-25 *	79	5	5-20	.	.		1	0	0-97	1	0	0-98	5	0	2-69	2	50	4-92	1	0	0-97	14	0	7-51
FIFTH AVENUE MEDICAL CENTE SEATTLE WA 98125	WA-26	237	8	7-17	3	67	7-88	3	0	3-83	6	0	1-63	10	10	7-58	5	40	11-82	16	25	8-50	33	12	11-40
FORKS COMMUNITY HOSPITAL FORKS WA 98331	WA-27 *	56	14	9-30	3	100	9-90	1	0	0-97	.	.		5	0	4-71	5	0	10-80	.	.		11	27	6-55
FRED HUTCHINSON CANCER RES SEATTLE WA 98104	WA-28 *	2	0	2-90	2	0	2-90	.	.		.	.		.	.		.	.		.	.		.	.	
GARFIELD MEMORIAL HOSPITAL POMEROY WA 99347	WA-29 *	22	23	4-34	1	100	3-99	.	.		1	0	0-100	3	33	2-81	1	100	2-98	.	.		3	0	0-84
GENERAL HOSPITAL OF EVERET EVERETT WA 98201	WA-30 *	1833	10	7-14	87	18	13-34	53	32	17-42	39	28	8-34	66	27	14-35	91	30	28-49	46	11	6-32	102	19	11-28
GOOD SAMARITAN HOSPITAL PUYALLUP WA 98371	WA-31	1796	12	8-15	83	23	13-34	56	32	17-41	68	25	9-30	104	15	14-30	56	43	25-51	50	24	13-39	177	25	13-27
GRAYS HARBOR COMMUNITY HOS ABERDEEN WA 98520	WA-32	839	12	8-16	68	13	9-30	38	39	16-45	21	19	5-39	49	24	13-37	39	41	23-53	22	14	7-43	80	18	9-27
GROUP HEALTH HOSPITAL SEATTLE WA 98102	WA-33 *	5455	8	7-13	489	18	17-31	178	15	20-35	114	15	10-28	193	25	18-31	115	37	28-47	96	23	10-31	340	20	14-26
HARBORVIEW MEDICAL CENTER SEATTLE WA 98104	WA-34	1276	14	7-14	38	32	14-44	50	46	15-40	27	37	8-40	46	30	13-38	70	47	26-50	21	14	3-37	87	13	9-26
HARRISON MEMORIAL HOSPITAL BREMERTON WA 98310	WA-35 *	2775	11	8-15	178	20	15-32	96	25	19-39	53	15	7-29	111	20	16-33	98	39	28-49	72	15	9-31	232	20	14-27
HIGHLINE COMMUNITY HOSPITA SEATTLE WA 98166	WA-36	1097	16	10-18	74	38	19-42	32	34	17-49	31	29	9-39	62	24	14-35	49	47	26-54	27	15	8-41	106	25	13-31

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
AUBURN GENERAL HOSPITAL AUBURN WA 98002	10	40	6-80	3	0	4-84	47	6	3-21	.	.		112	5	1-10	62	13	1-15	6	0	0-100	86	15	1-11	70	0	0-11
BALLARD COMMUNITY HOSPITAL SEATTLE WA 98107	13	23	7-57	11	18	13-66	69	13	4-19	3	0	0-100	137	5	3-12	41	0	0-21	11	9	0-99	74	4	2-14	117	3	0-7
BLACK HILLS COMMUNITY HOSP OLYMPIA WA 98502	4	0	4-79	3	33	3-84	15	0	1-36	.	.		49	10	2-17	24	13	1-27	6	0	0-100	54	3	1-20	20	5	0-38
CASCADE GENERAL HOSPITAL LEAVENWORTH WA 98826	2	0	0-91	1	0	2-98	2	50	0-95	.	.		9	11	0-50	2	50	1-89	.	.		12	8	0-42	14	0	0-39
CASCADE VALLEY HOSPITAL ARLINGTON WA 98223	2	50	2-91	4	50	12-87	13	15	1-41	2	0	0-100	39	10	2-21	12	17	0-43	3	0	0-100	22	5	0-26	24	4	0-28
CENTRAL WASHINGTON HEALTH WENATCHEE WA 98801	22	18	10-51	6	17	8-73	61	8	4-20	28	0	0-81	170	7	2-10	143	1	1-11	30	0	0-39	147	5	2-9	268	0	0-4
CENTRALIA GENERAL HOSPITAL CENTRALIA WA 98531	3	0	1-82	5	0	7-77	30	10	2-24	4	0	0-100	80	5	2-15	49	0	1-17	11	0	0-99	85	3	2-12	59	3	0-12
COLUMBIA BASIN HOSPITAL EPHRATA WA 98823	3	33	5-86	.	.		.	.		.	.		10	20	0-48	.	.		.	.		6	0	0-79	1	0	0-100
COMMUNITY MEMORIAL HOSPITA ENUMCLAW WA 98022	4	50	2-77				14	7	2-41	.	.		31	6	1-21	12	0	0-53	7	0	0-100	19	0	1-30	13	0	0-69
COULEE COMMUNITY HOSPITAL GRAND COULEE WA 99133	.	.		.	.		1	0	0-100	.	.		8	0	0-58	.	.		.	.		6	0	0-70	.	.	
DAYTON GENERAL HOSPITAL DAYTON WA 99328	.	.		1	0	0-97	10	0	1-47	.	.		8	13	0-55	.	.		.	.		6	0	0-54	6	0	0-81
DEACONESS HOSPITAL SPOKANE WA 99210	17	12	11-57	16	19	15-61	73	8	5-21	76	0	0-14	210	4	3-11	158	1	1-11	59	0	0-31	412	4	3-8	198	1	0-5
DEER PARK HEALTH CENTER HO DEER PARK WA 99006	5	0	4-74	.	.		.	.		.	.		10	0	0-53	3	0	0-84	.	.		17	6	0-32	3	33	0-97
EVERGREEN HOSPITAL MEDICAL KIRKLAND WA 98033	5	40	3-73	7	14	6-67	50	8	3-21	.	.		91	10	3-14	51	2	0-17	17	0	0-94	73	7	2-13	84	0	0-9
FERRY COUNTY MEMORIAL HOSP REPUBLIC WA 99166	.	.		.	.		.	.		.	.		6	0	0-73	3	0	0-85	1	0	0-100	19	0	1-29	4	0	0-100
FIFTH AVENUE MEDICAL CENTE SEATTLE WA 98125	2	0	2-90	1	0	0-97	6	0	1-62	1	0	0-100	15	0	0-37	11	0	0-63	1	0	0-100	11	0	0-44	41	0	0-25
FORKS COMMUNITY HOSPITAL FORKS WA 98331	2	50	6-95	.	.		.	.		.	.		3	0	0-85	1	0	0-98	.	.		2	0	0-97	4	0	0-99
FRED HUTCHINSON CANCER RES SEATTLE WA 98104	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
GARFIELD MEMORIAL HOSPITAL POMEROY WA 99347	.	.		.	.		.	.		.	.		5	0	0-86	.	.		.	.		1	0	0-100	1	0	0-100
GENERAL HOSPITAL OF EVERET EVERETT WA 98201	11	0	4-56	12	17	12-63	66	5	3-19	.	.		135	6	2-11	64	3	0-16	29	0	0-63	329	5	3-8	141	0	0-6
GOOD SAMARITAN HOSPITAL PUYALLUP WA 98371	12	8	5-55	13	8	14-64	50	12	3-21	1	0	0-100	128	8	3-13	77	3	1-14	19	0	0-57	112	4	2-10	147	1	0-6
GRAYS HARBOR COMMUNITY HOS ABERDEEN WA 98520	6	0	2-66	4	75	5-81	25	4	3-30	.	.		110	6	2-11	48	2	1-17	2	0	0-100	57	7	1-14	49	2	0-15
GROUP HEALTH HOSPITAL SEATTLE WA 98102	27	7	6-43	27	26	20-57	92	9	3-15	428	0	0-2	519	3	2-7	274	1	1-9	92	0	0-44	268	2	3-8	617	1	0-3
HARBORVIEW MEDICAL CENTER SEATTLE WA 98104	15	33	6-53	8	88	15-75	58	22	3-20	3	0	0-100	65	12	2-15	26	4	0-25	3	0	0-100	35	3	1-19	66	5	0-12
HARRISON MEMORIAL HOSPITAL BREMERTON WA 98310	28	11	7-45	34	24	17-50	96	7	4-18	10	0	0-100	256	8	3-10	146	3	1-11	24	0	0-85	205	4	2-8	250	2	0-5
HIGHLINE COMMUNITY HOSPITA SEATTLE WA 98166	13	23	8-58	18	39	15-58	40	8	4-24	3	33	0-100	84	5	3-16	40	0	1-19	12	0	0-50	94	4	2-11	55	0	1-13

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HOLY FAMILY HOSPITAL SPOKANE WA 99207	WA-37	1789	14	10-16	158	22	16-34	78	37	20-41	50	20	7-30	104	22	15-33	57	51	27-53	33	15	7-36	160	28	14-28
HOSPICE CARE CENTER HOSPIT LONGVIEW, WASHINGTON 98632	WA-38 *	1	100	3-99	1	100	3-99	.	.		.	.		.	.		.	.		.	.		.	.	
HUMANA HOSPITAL-TACOMA TACOMA WA 98411	WA-39	1146	12	8-15	104	27	16-36	38	24	16-45	43	21	7-32	51	20	15-39	20	45	25-67	29	17	6-37	88	20	13-32
ISLAND HOSPITAL ANACORTES WA 98221	WA-40	564	13	9-17	63	27	14-38	12	33	12-61	28	14	4-32	19	21	9-47	21	24	22-63	6	17	7-71	47	19	10-35
JEFFERSON GENERAL HOSPITAL PORT TOWNSENO WA 98368	WA-41 *	365	16	9-18	27	41	11-44	18	50	16-57	13	15	4-48	22	32	10-46	12	17	16-67	3	33	0-83	34	21	7-34
KAOLEC MEOICAL CENTER RICHLAND WA 99352	WA-42	894	12	8-15	67	37	15-39	33	18	15-46	23	13	5-37	38	32	14-41	33	30	22-55	18	22	6-44	72	22	9-28
KENNEWICK GENERAL HOSPITAL KENNEWICK WA 99336	WA-43	562	14	9-17	47	19	12-38	22	32	16-53	14	14	3-44	29	17	11-42	27	37	24-60	6	0	3-65	53	21	10-33
KITTITAS VALLEY COMMUNITY ELLENSBURG WA 98926	WA-44	351	15	9-18	15	20	7-50	21	52	12-49	17	24	3-39	21	5	8-43	29	28	20-55	6	17	2-64	31	32	7-35
KLICKITAT VALLEY HOSPITAL GOLDENOALE WA 98620	WA-45 *	142	21	9-22	5	80	4-72	4	50	2-75	7	14	3-62	6	50	6-69	14	57	19-67	3	0	0-83	18	33	5-42
LAKE CHELAN COMMUNITY HOSP CHELAN WA 98816	WA-46 *	117	6	5-18	5	40	5-73	7	29	6-65	4	0	0-76	5	0	3-69	.	.		5	0	0-71	7	14	3-60
LAKEWOOD GENERAL HOSPITAL TACOMA WA 98499	WA-47	696	13	8-16	44	11	12-39	25	48	14-49	12	17	6-52	42	24	11-36	42	50	22-51	17	18	5-44	77	18	10-29
LINCOLN HOSPITAL OAVENPORT WA 99122	WA-48	140	11	9-22	12	17	10-59	4	50	3-76	10	0	2-50	10	30	7-58	10	30	13-68	4	0	2-75	19	5	6-43
MAOIGAN GEN HOSP TACOMA WA 98431	WA-49 *	2	50	0-99	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
MARK E REEO MEMORIAL HOSPI MC CLEARY WA 98557	WA-50	120	16	11-26	1	100	3-99	3	0	5-85	1	0	0-99	12	33	10-58	8	13	12-72	3	33	6-87	42	14	10-35
MASON GENERAL HOSPITAL SHELTON WA 98584	WA-51 *	550	11	9-17	32	28	13-45	21	24	15-53	17	6	5-43	43	23	11-36	26	31	21-58	17	12	6-46	57	23	12-35
MEOICAL-DENTAL BUILOING HO SEATTLE WA 98101	WA-52 *	41	0	0-22	.	.		.	.		.	.		.	.		.	.		.	.		1	0	0-99
MEMORIAL HOSPITAL-OOESSA OOESSA WA 99159	WA-53	16	13	3-39	.	.		1	0	0-97	1	100	0-99	1	0	0-97	1	0	2-98	1	0	0-98	1	0	1-97
MEMORIAL HOSPITAL-PULLMAN PULLMAN WA 99163	WA-54 *	202	8	6-17	13	23	10-58	5	20	5-73	8	0	3-57	5	20	5-74	.	.		6	17	2-64	24	21	7-40
MIO-VALLEY HOSPITAL OMAK WA 98841	WA-55 *	236	11	8-18	17	12	6-45	9	56	10-66	13	8	3-45	14	29	7-49	15	13	17-63	5	40	1-69	25	12	6-36
MONTICELLO MEOICAL CENTER LONGVIEW WA 98632	WA-56 *	359	9	8-17	16	13	8-49	11	36	10-60	3	33	1-81	20	10	8-43	21	33	19-59	4	0	0-76	29	10	9-39
MORTON GENERAL HOSPITAL MORTON WA 98356	WA-57 *	98	13	7-22	6	67	7-72	4	0	4-78	4	0	0-76	5	0	2-68	6	17	10-76	2	50	0-90	10	10	2-50
MOUNT CARMEL HOSPITAL COLVILLE WA 99114	WA-58 *	312	12	8-17	13	15	6-50	15	40	10-53	15	27	4-44	22	14	8-43	17	18	16-59	1	0	0-98	37	16	8-35
MOUNT LINTON HOSPITAL METALINE FALLS WA 99153	WA-59 *	28	18	7-35	1	0	0-97	.	.		1	0	0-97	5	0	5-72	1	0	0-97	2	0	0-93	6	33	4-66
NEW VALLEY OSTEOPATHIC HOS YAKIMA WA 98902	WA-60 *	284	11	8-17	19	26	7-45	7	57	7-67	7	0	2-59	16	19	7-47	15	33	17-63	7	0	1-59	37	11	6-32
NEWPORT COMMUNITY HOSPITAL NEWPORT WA 99156	WA-61 *	91	7	6-21	3	0	1-81	4	0	5-79	5	20	2-69	4	50	3-76	3	0	6-87	6	0	1-65	14	7	5-46
NORTH VALLEY HOSPITAL TONASKET WA 98855	WA-62 *	141	14	8-21	6	0	5-69	5	60	5-72	2	0	0-91	8	50	8-65	5	40	14-85	3	0	1-82	23	30	9-43

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
HDLY FAMILY HDSPITAL SPOKANE WA 99207	8	25	4-62	20	35	21-63	65	12	3-19	3	0	0-100	150	8	2-10	79	4	2-14	18	0	0-81	115	3	2-11	166	1	0-6
HOSPICE CARE CENTER HOSPIT LDNGVIEW, WASHINGTON 98632	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
HUMANA HOSPITAL-TACOMA TACOMA WA 98411	9	33	4-59	7	43	11-73	54	7	4-22	89	0	0-12	131	5	2-11	53	2	1-16	11	0	0-99	58	7	1-15	63	11	0-11
ISLAND HOSPITAL ANACORTES WA 98221	6	0	3-68	9	67	16-74	18	6	1-33	1	0	0-100	48	13	2-17	30	0	0-25	9	0	0-97	43	5	1-17	31	6	0-20
JEFFERSDN GENERAL HDSPITAL PORT TDWNSEND WA 98368	4	0	1-76	5	20	10-80	13	15	3-44	1	0	0-100	41	5	3-22	35	3	1-21	.	.		23	0	0-25	23	4	0-31
KADLEC MEDICAL CENTER RICHLAND WA 99352	3	0	1-82	4	25	6-80	25	12	2-28	2	0	0-100	104	7	2-12	60	2	0-16	11	0	0-100	52	6	1-15	89	0	0-9
KENNEWICK GENERAL HDSPITAL KENNEWICK WA 99336	4	50	4-78	5	40	8-79	14	0	1-39	.	.		56	11	2-16	45	7	0-19	7	0	0-100	29	7	1-21	37	3	0-22
KITTITAS VALLEY COMMUNITY ELLENSBURG WA 98926	2	0	2-90	4	0	10-85	17	18	1-34	.	.		36	6	1-19	7	14	1-58	2	0	0-100	25	4	1-25	29	3	0-23
KLICKITAT VALLEY HOSPITAL GOLDENDALE WA 98620	6	33	5-70	.	.		.	.		.	.		18	6	1-31	1	0	0-100	.	.		14	0	0-39	4	0	0-100
LAKE CHELAN COMMUNITY HOSP CHELAN WA 98816	4	0	1-76	2	0	1-89	3	0	0-91	.	.		15	7	1-36	1	0	0-100	1	0	0-100	8	0	0-58	3	0	0-100
LAKEWOOD GENERAL HOSPITAL TACOMA WA 98499	3	0	1-82	1	0	0-97	34	0	3-25	.	.		76	8	2-13	41	10	1-19	17	0	0-97	39	5	1-19	56	4	0-14
LINCOLN HOSPITAL DAVENPORT WA 99122	2	50	0-91	2	0	1-89	2	0	0-90	.	.		15	0	0-38	5	0	0-96	.	.		9	0	0-53	4	0	0-94
MADIGAN GEN HOSP TACOMA WA 98431	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
MARK E REED MEMORIAL HOSPI MC CLEARY WA 98557	5	20	3-72	.	.		.	.		1	0	0-100	5	0	0-80	4	0	0-78	.	.		7	14	0-63	2	0	0-97
MASON GENERAL HOSPITAL SHELTON WA 98584	4	50	2-76	2	50	2-90	21	0	3-33	.	.		61	10	2-16	17	0	0-37	9	0	0-60	72	3	1-13	26	0	0-26
MEDICAL-DENTAL BUILDING HO SEATTLE WA 98101	.	.		.	.		.	.		.	.		1	0	0-100	.	.		2	0	0-100	.	.		25	0	0-39
MEMORIAL HOSPITAL-ODESSA ODESSA WA 99159	.	.		.	.		.	.		.	.		1	100	0-99	.	.		.	.		3	0	0-90	1	0	0-100
MEMORIAL HOSPITAL-PULLMAN PULLMAN WA 99163	2	50	8-97	.	.		12	0	1-42	.	.		17	12	1-33	8	0	0-58	5	0	0-100	7	14	0-58	25	0	0-44
MID-VALLEY HOSPITAL OMAK WA 98841	.	.		.	.		3	33	1-81	1	0	0-100	24	0	1-26	8	0	0-95	5	0	0-100	15	7	0-37	11	9	0-61
MONTICELLO MEDICAL CENTER LONGVIEW WA 98632	3	33	1-82	4	25	4-78	11	0	1-45	.	.		35	9	2-21	24	0	0-30	15	0	0-99	36	3	1-20	18	0	0-37
MORTON GENERAL HOSPITAL MORTON WA 98356	1	0	0-97	3	33	6-87	1	0	0-100	.	.		8	0	0-60	4	0	0-81	1	0	0-100	4	0	0-91	5	0	0-100
MOUNT CARMEL HOSPITAL COLVILLE WA 99114	3	33	0-83	2	50	4-92	12	0	0-43	2	0	0-100	39	5	1-18	3	0	0-86	.	.		27	4	1-23	9	0	0-83
MOUNT LINTON HOSPITAL METALINE FALLS WA 99153	.	.		.	.		.	.		.	.		.	.		1	100	0-98	1	0	0-100	3	0	0-88	.	.	
NEW VALLEY OSTEOPATHIC HOS YAKIMA WA 98902	.	.		4	50	5-80	12	17	3-46	1	0	0-100	32	0	1-21	10	0	0-47	7	0	0-95	21	0	1-28	18	6	0-32
NEWPORT COMMUNITY HOSPITAL NEWPORT WA 99156	1	0	0-98	1	0	2-98	.	.		.	.		10	0	0-47	2	0	0-95	1	0	0-100	8	0	0-56	3	0	0-96
NORTH VALLEY HOSPITAL TONASKET WA 98855	2	0	1-90	.	.		2	0	0-98	.	.		16	0	1-34	3	0	0-98	.	.		10	0	0-48	7	0	0-89

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
NORTHGATE GENERAL HOSPITAL SEATTLE WA 98125	WA-63 *	535	13	9-17	32	13	9-38	21	38	15-53	19	11	6-43	23	35	9-44	28	50	22-58	14	14	3-44	58	19	13-36
NORTHWEST HOSPITAL SEATTLE WA 98133	WA-64	2159	11	9-16	176	17	15-32	80	34	18-39	63	25	11-34	93	24	15-33	81	35	27-49	50	20	13-39	145	25	14-30
OCEAN BEACH HOSPITAL ILWACO WA 98624	WA-65	256	12	10-20	15	33	9-52	11	27	10-61	11	9	2-47	16	31	8-49	18	11	17-60	9	11	3-54	45	18	9-33
OKANOGAN-DOUGLAS COUNTY HD BREWSTER WA 98812	WA-66 *	258	13	10-21	24	21	13-50	18	44	15-57	11	0	4-50	6	17	3-64	10	60	17-72	3	0	1-81	32	22	12-42
OLYMPIC MEMORIAL HOSPITAL PORT ANGELES WA 98362	WA-67	1347	10	8-15	81	19	13-34	46	24	17-44	23	13	6-39	75	21	13-33	44	34	23-52	27	30	10-44	121	17	14-30
OTHELLO COMMUNITY HOSPITAL OTHELLO WA 99344	WA-68	87	13	8-24	4	0	3-76	6	33	7-71	3	33	5-85	7	14	4-63	4	50	7-82	3	33	0-82	13	15	4-46
OUR LADY OF LOURDES HOSPIT PASCO WA 99301	WA-69	621	11	9-17	45	20	11-38	30	17	14-46	15	7	6-47	31	19	11-40	33	42	23-56	16	0	5-45	59	22	9-30
OVERLAKE HOSPITAL MEDICAL BELLEVUE WA 98004	WA-70	1960	11	8-15	176	31	17-34	65	29	19-42	47	13	11-36	67	22	15-36	64	42	27-52	26	15	6-38	143	15	13-29
PACIFIC MEDICAL CENTER SEATTLE WA 98144	WA-71 *	299	10	8-18	24	17	11-46	6	50	8-72	13	0	3-45	19	16	8-45	7	43	13-76	8	25	2-56	32	16	10-39
PROSSER MEMORIAL HOSPITAL PROSSER WA 99350	WA-72 *	142	13	9-22	12	8	7-54	9	44	11-66	4	0	0-76	12	8	6-52	6	67	13-79	5	0	2-69	26	12	6-36
PROVIDENCE CENTRAL MEMORIA TOPPENISH WA 98948	WA-73	274	17	9-19	9	33	6-60	19	32	14-54	7	14	2-60	14	14	9-53	19	37	17-58	5	0	1-68	36	28	10-37
PROVIDENCE HOSPITAL EVERETT WA 98201	WA-74	2095	14	10-16	201	33	20-36	61	31	18-41	42	12	13-41	96	34	16-34	66	41	27-51	18	28	9-50	193	23	13-27
PROVIDENCE MEDICAL CENTER SEATTLE WA 98122	WA-75	2982	9	7-13	211	21	15-31	92	21	19-38	50	20	8-32	106	19	14-31	90	38	26-48	38	26	7-35	156	21	15-30
PUGET SOUND HOSPITAL TACOMA WA 98408	WA-76	750	9	7-14	34	26	12-43	24	33	15-51	19	26	8-46	36	11	12-39	30	60	21-56	9	11	2-54	44	9	8-32
QUINCY VALLEY HOSPITAL QUINCY WA 98848	WA-77	52	12	5-23	.	.		3	33	3-84	.	.		2	0	0-90	.	.		.	.		10	10	5-54
RITZVILLE MEMORIAL HOSPITA RITZVILLE WA 99169	WA-78 *	97	11	8-23	3	33	3-83	9	33	9-65	6	0	1-63	5	40	3-69	2	0	2-90	6	0	3-65	21	0	7-41
RIVERTON GENERAL HOSPITAL SEATTLE WA 98168	WA-79 *	588	10	7-14	35	26	10-40	16	31	11-53	15	20	6-47	41	17	11-37	16	25	20-66	9	11	4-56	39	21	8-33
SACRED HEART MEDICAL CENTE SPOKANE WA 99204	WA-80	4575	12	9-15	373	20	17-32	123	30	19-36	85	19	10-29	138	22	17-32	210	30	29-45	77	26	12-35	311	23	15-27
SAMARITAN HOSPITAL MOSES LAKE WA 98837	WA-81 *	421	11	7-16	26	46	13-48	11	18	7-55	12	33	5-51	22	23	9-43	9	44	15-72	16	25	3-42	50	14	10-33
SHOREWOOD OSTEOPATHIC HOSP SEATTLE WA 98146	WA-82 *	175	15	8-20	6	50	6-70	7	29	6-66	5	0	0-71	14	29	7-50	7	57	11-73	9	33	5-58	24	4	7-39
SKAGIT VALLEY HOSPITAL & H MOUNT VERNON WA 98273	WA-83	1164	10	9-16	109	23	18-38	46	11	17-43	23	9	7-40	40	18	13-40	53	34	26-53	9	33	5-59	83	27	11-30
SKYLINE HOSPITAL WHITE SALMON WA 98672	WA-84 *	160	12	9-21	7	57	7-68	4	25	4-78	4	0	1-74	12	8	9-56	13	38	14-63	3	0	5-86	16	19	7-47
SNOQUALMIE VALLEY HOSPITAL SNOQUALMIE WA 98065	WA-85 *	126	11	7-20	4	0	1-74	7	57	11-73	4	0	2-74	8	13	3-57	5	60	12-83	2	0	0-92	8	25	5-60
ST ELIZABETH MEDICAL CENTE YAKIMA WA 98902	WA-86	1951	11	8-15	141	16	15-33	55	31	17-42	52	12	9-33	115	23	16-33	73	37	28-52	21	19	9-47	143	15	12-28
ST HELEN HOSPITAL CHEHALIS WA 98532	WA-87 *	564	14	9-17	30	23	10-42	17	41	14-56	10	10	2-50	45	22	14-39	25	48	24-62	2	0	2-90	50	24	14-39
ST JOHN'S HOSPITAL LONGVIEW WA 98632	WA-88	1716	12	9-16	156	22	16-34	62	27	18-42	28	32	10-42	95	18	15-32	63	41	27-52	22	9	8-44	121	16	13-29

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Oisease			Sepsis			Severe Trauma			Ophthalmology			GI Oisease			Urology			Gynecology			Low Risk Heart Oisease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
NORTHGATE GENERAL HOSPITAL SEATTLE WA 98125	6	33	5-70	3	67	2-83	33	9	3-27	10	0	0-99	46	4	2-18	30	3	0-24	5	0	0-100	33	9	1-21	32	3	0-26
NORTHWEST HOSPITAL SEATTLE WA 98133	24	25	11-51	8	38	17-78	86	8	5-19	.	.		150	7	3-11	136	1	1-11	32	0	0-86	99	2	2-12	177	0	0-6
OCEAN BEACH HOSPITAL ILWACO WA 98624	2	0	4-92	4	0	4-78	1	0	0-100	.	.		27	7	2-25	17	0	1-34	1	0	0-100	23	0	1-25	2	0	0-100
OKANOGAN-DOUGLAS COUNTY HO BREWSTER WA 98812	.	.		.	.		8	13	1-53	1	0	0-100	21	10	1-28	14	0	1-38	6	0	0-100	22	0	1-27	11	0	0-67
OLYMPIC MEMORIAL HOSPITAL PORT ANGELES WA 98362	20	15	11-54	13	23	13-62	45	7	3-23	5	0	0-100	122	6	2-11	79	1	1-14	17	0	0-88	141	4	2-9	80	4	0-10
OTHELLO COMMUNITY HOSPITAL OTHELLO WA 99344	.	.		.	.		.	.		.	.		12	8	1-41	2	0	0-93	.	.		14	7	0-38	3	0	0-96
OUR LADY OF LOUROES HOSPIT PASCO WA 99301	3	33	2-83	6	17	7-72	19	16	1-32	1	100	0-100	66	6	2-15	29	3	0-24	10	0	0-100	60	7	1-14	29	3	0-23
OVERLAKE HOSPITAL MEOICAL 8ELLEVUE WA 98004	9	11	4-59	16	38	19-66	63	11	4-20	7	0	0-99	186	8	3-10	97	1	0-13	27	0	0-82	170	2	2-9	176	0	0-5
PACIFIC MEOICAL CENTER SEATTLE WA 98144	9	11	3-59	3	100	9-90	2	0	0-93	1	0	0-100	22	5	1-28	11	0	0-53	2	0	0-100	27	4	1-23	18	0	0-65
PROSSER MEMORIAL HOSPITAL PROSSER WA 99350	1	0	0-100	2	50	2-90	.	.		.	.		15	7	0-36	2	0	0-92	.	.		12	8	0-42	.	.	
PROVIOENCE CENTRAL MEMORIA TOPPENISH WA 98948	4	25	1-77	4	100	9-85	5	0	0-69	1	0	0-100	28	4	1-24	11	0	0-55	2	0	0-100	28	7	1-22	13	0	0-53
PROVIOENCE HOSPITAL EVERETT WA 98201	27	19	8-46	17	12	16-61	57	7	5-22	12	0	0-100	161	7	3-11	97	0	1-12	11	0	0-97	161	4	2-9	153	1	0-6
PROVIOENCE MEDICAL CENTER SEATTLE WA 98122	17	29	9-54	9	44	10-66	48	8	4-22	3	0	0-100	191	5	3-10	76	3	1-14	23	0	0-94	603	3	4-8	253	1	0-5
PUGET SOUNO HOSPITAL TACOMA WA 98408	7	0	4-65	2	0	4-92	14	0	2-39	.	.		53	4	1-15	28	4	0-25	7	0	0-100	26	4	1-24	33	3	0-21
QUINCY VALLEY HOSPITAL QUINCY WA 98848	2	50	1-90	.	.		.	.		.	.		3	0	0-88	2	50	1-89	1	0	0-100	12	0	0-42	.	.	
RITZVILLE MEMORIAL HOSPITA RITZVILLE WA 99169	.	.		.	.		.	.		.	.		6	17	0-62	1	0	0-99	.	.		4	25	0-81	3	0	0-99
RIVERTON GENERAL HOSPITAL SEATTLE WA 98168	2	0	4-92	2	50	6-94	38	8	3-23	.	.		48	6	1-16	19	0	0-33	11	0	0-100	43	2	1-16	65	3	0-12
SACRED HEART MEOICAL CENTE SPOKANE WA 99204	83	23	11-39	63	30	24-51	133	8	5-16	8	0	0-100	335	9	3-9	178	3	1-11	39	0	0-29	552	5	3-8	368	2	0-4
SAMARITAN HOSPITAL MOSES LAKE WA 98837	5	0	0-77	.	.		28	4	2-27	1	0	0-100	41	2	1-18	2	0	0-100	6	0	0-100	36	3	1-19	56	0	0-12
SHOREWOOO OSTEOPATHIC HOSP SEATTLE WA 98146	4	50	3-78	.	.		11	0	1-44	.	.		17	12	0-33	2	0	0-93	1	100	0-100	9	0	0-56	8	0	0-94
SKAGIT VALLEY HOSPITAL & H MOUNT VERNON WA 98273	9	33	6-63	13	38	12-60	28	7	2-27	2	0	0-100	114	6	1-10	60	0	0-16	17	0	0-97	80	4	2-13	118	0	0-7
SKYLINE HOSPITAL WHITE SALMON WA 98672	2	0	5-93	1	0	0-97	.	.		.	.		12	8	1-41	2	0	0-100	.	.		15	0	0-35	7	0	0-90
SNOQUALMIE VALLEY HOSPITAL SNOQUALMIE WA 98065	4	25	6-81	.	.		4	0	0-80	.	.		7	14	0-72	10	0	1-47	1	0	0-100	15	7	1-35	16	0	0-62
ST ELIZABETH MEDICAL CENTE YAKIMA WA 98902	16	25	7-52	14	29	14-63	44	9	3-23	1	0	0-100	153	3	2-10	98	9	1-13	12	0	0-95	286	7	3-8	135	1	0-7
ST HELEN HOSPITAL CHEHALIS WA 98532	5	40	4-73	2	50	7-95	24	4	2-29	.	.		62	8	1-14	23	17	2-31	17	0	0-94	35	6	1-19	12	0	0-73
ST JOHN'S HOSPITAL LONGVIEW WA 98632	10	10	9-64	26	46	19-57	53	15	3-21	2	0	0-100	172	11	3-11	63	2	1-15	15	7	0-43	159	8	2-10	108	2	0-8

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST JOSEPH COMMUNITY HDSPIT VANCOUVER WA 98664	WA-89	1645	12	10-17	139	14	13-31	116	20	19-36	43	16	8-34	74	22	14-34	104	30	28-48	38	5	9-37	126	21	13-29
ST JOSEPH HDSPITAL ABERDEEN WA 98520	WA-90	413	9	9-18	21	33	11-48	15	0	11-54	11	27	3-48	27	15	10-42	17	29	16-60	17	29	9-51	31	10	7-36
ST JOSEPH HOSPITAL HEALTH TACOMA WA 98401	WA-91	2621	11	9-15	166	16	18-36	83	29	20-40	42	24	12-39	142	28	18-33	75	41	25-48	51	12	10-35	176	19	13-28
ST JOSEPH'S HDSPITAL BELLINGHAM WA 98225	WA-92 *	1150	9	8-15	155	15	13-30	32	34	15-46	23	26	6-40	39	21	11-37	50	28	27-54	22	18	6-41	85	15	10-28
ST JOSEPH'S HOSPITAL CHEWELAH WA 99109	WA-93 *	255	8	6-16	6	17	8-73	5	20	3-71	3	0	0-86	11	45	6-55	6	0	10-75	6	0	1-63	30	7	10-40
ST LUKE'S GENERAL HOSPITAL BELLINGHAM WA 98225	WA-94	1280	11	9-16	84	19	13-34	79	35	18-39	31	13	7-36	60	17	13-34	66	27	29-53	15	20	9-52	105	19	13-31
ST LUKE'S MEMORIAL HDSPITA SPOKANE WA 99210	WA-95	600	10	6-14	32	22	15-47	15	20	9-52	7	14	3-62	30	17	11-41	14	36	18-66	14	21	4-46	43	12	6-29
ST PETER HOSPITAL OLYMPIA WA 98501	WA-96	3124	12	9-16	269	20	16-31	154	30	20-36	62	13	13-36	134	28	16-32	129	40	30-49	53	25	9-34	265	23	14-27
ST. CABRINI HOSPITAL OF SE SEATTLE WA 98104	WA-97	1063	8	6-13	66	32	15-38	26	31	15-50	21	14	7-43	45	18	14-40	13	31	15-64	14	14	3-44	70	24	14-35
ST. MARY MEDICAL CENTER WALLA WALLA WA 99362	WA-98 *	1098	11	8-15	91	20	14-35	28	36	12-44	13	23	3-45	44	5	13-38	43	35	24-53	18	6	6-45	80	25	10-29
STEVENS MEMORIAL HOSPITAL EDMONDS WA 98020	WA-99	1487	12	9-15	98	20	13-33	53	40	19-44	43	14	7-32	66	20	14-35	65	48	28-53	26	27	9-43	121	19	14-31
SUNNYSIDE GENERAL HOSPITAL SUNNYSIDE WA 98944	WA-100*	465	14	9-18	46	30	15-42	18	33	15-56	11	36	4-52	34	35	13-43	14	50	16-63	23	13	7-42	34	9	8-35
SWEDISH HOSPITAL MEDICAL C SEATTLE WA 98104	WA-101	5041	12	9-15	622	22	19-32	158	27	20-36	143	21	13-30	171	22	18-31	140	29	30-48	75	19	11-34	320	22	15-27
TACOMA GENERAL HOSPITAL TACOMA WA 98405	WA-102	2848	14	9-15	267	24	18-34	125	31	21-38	66	17	9-30	120	22	17-33	107	39	27-47	48	23	9-35	190	22	13-27
TRI-STATE MEMORIAL HOSPITA CLARKSTON WA 99403	WA-103	413	8	6-15	38	21	10-38	12	25	12-61	13	8	5-49	13	23	8-54	12	42	19-70	14	14	4-46	24	8	8-41
UNITED GENERAL HOSPITAL SEDRO WOOLLEY WA 98284	WA-104*	809	13	10-17	41	20	14-42	37	38	18-48	26	35	10-43	36	22	12-40	34	26	22-55	22	27	8-45	71	24	13-33
UNIVERSITY HOSPITAL SEATTLE WA 98195	WA-105	1676	10	6-13	141	24	17-35	19	42	13-53	18	28	7-46	42	14	12-38	29	38	19-53	24	25	8-42	61	23	9-30
VALLEY GENERAL HOSPITAL MONROE WA 98272	WA-106*	321	9	6-15	22	9	7-43	8	50	8-65	6	17	1-63	11	27	8-57	8	38	14-74	5	0	3-70	32	13	7-34
VALLEY HOSPITAL & MEDICAL SPOKANE WA 99216	WA-107	1106	11	9-16	85	26	15-36	35	40	18-48	23	17	6-39	52	13	13-37	35	51	26-59	21	5	6-42	105	21	15-32
VALLEY MEDICAL CENTER RENTON WA 98055	WA-108	1796	14	9-15	142	26	16-34	55	31	16-40	46	26	9-34	92	32	14-32	79	43	27-50	55	24	13-38	123	20	11-27
VANCOUVER MEMORIAL HOSPITA VANCOUVER WA 98663	WA-109	599	10	8-15	38	29	11-40	11	18	11-62	19	32	9-48	26	27	10-42	32	25	23-56	16	13	3-42	35	14	11-39
VIRGINIA MASON HOSPITAL SEATTLE WA 98101	WA-110	3069	8	8-14	412	18	18-33	53	23	17-42	58	14	9-31	86	19	15-34	68	28	27-51	38	11	7-34	164	16	15-30
WALLA WALLA GENERAL HOSPIT WALLA WALLA WA 99362	WA-111*	539	11	7-15	34	26	13-43	7	29	7-68	13	15	2-44	29	38	11-42	20	45	22-64	20	15	7-44	42	10	9-34
WEST SEATTLE COMMUNITY HOS SEATTLE WA 98126	WA-112*	518	10	10-19	47	17	11-37	22	36	15-52	22	14	7-41	21	14	11-47	33	30	27-60	23	9	7-41	48	19	10-34
WHIDBEY GENERAL HOSPITAL COUPEVILLE WA 98239	WA-113	502	13	8-17	49	8	10-35	25	32	11-45	11	18	4-51	21	24	7-41	37	41	23-54	3	33	1-81	44	23	9-33
WHITMAN COMMUNITY HOSPITAL COLFAX WA 99111	WA-114*	191	11	8-19	17	12	10-51	4	0	3-76	5	40	0-69	6	17	5-67	8	25	14-74	4	0	0-76	29	17	8-37

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST JOSEPH COMMUNITY HOSPIT VANCOUVER WA 98664	13	38	9-59	16	25	18-64	52	2	3-20	9	0	0-100	123	6	2-11	87	3	1-13	10	0	0-100	103	5	2-12	143	1	0-6
ST JOSEPH HOSPITAL ABERDEEN WA 98520	5	0	3-72	5	40	11-82	21	5	2-31	2	0	0-100	39	3	1-19	12	0	1-43	4	0	0-100	44	2	1-16	12	0	1-41
ST JOSEPH HOSPITAL HEALTH TACOMA WA 98401	40	40	14-49	19	37	21-64	71	13	5-20	.	.		166	6	4-13	127	2	1-12	24	0	0-71	377	6	4-9	203	2	0-5
ST JOSEPH'S HOSPITAL BELLINGHAM WA 98225	12	8	5-54	12	8	12-62	40	8	3-24	3	0	0-100	98	5	2-12	76	1	0-14	24	0	0-89	89	3	2-12	116	0	0-7
ST JOSEPH'S HOSPITAL CHEWELAH WA 99109	5	20	1-72	1	0	3-99	.	.		1	0	0-100	23	4	1-26	3	0	0-97	2	0	0-100	25	0	1-24	12	0	0-81
ST LUKE'S GENERAL HOSPITAL BELLINGHAM WA 98225	4	25	5-80	14	29	16-64	77	5	3-18	1	0	0-100	114	7	3-13	52	2	0-17	6	0	0-100	117	3	2-11	75	0	0-10
ST LUKE'S MEMORIAL HOSPITA SPOKANE WA 99210	5	20	3-73	3	0	2-83	24	4	2-29	4	0	0-100	43	5	2-18	40	3	0-22	5	0	0-100	16	19	1-34	86	1	0-9
ST PETER HOSPITAL OLYMPIA WA 98501	36	8	10-45	18	39	17-61	88	10	4-17	7	0	0-100	258	5	3-10	129	4	1-11	56	0	0-24	264	4	3-8	235	2	1-5
ST. CABRINI HOSPITAL OF SE SEATTLE WA 98104	16	19	10-57	4	50	8-83	27	11	2-27	139	0	0-7	71	1	2-15	27	0	1-25	6	0	0-97	47	4	1-17	56	2	0-12
ST. MARY MEDICAL CENTER WALLA WALLA WA 99362	10	50	9-65	9	11	12-69	45	11	4-24	3	0	0-100	120	7	2-10	61	0	0-16	14	0	0-94	70	6	1-12	86	2	0-9
STEVENS MEMORIAL HOSPITAL EDMONDS WA 98020	16	31	6-51	6	0	9-75	71	8	3-18	1	0	0-100	113	5	2-11	53	2	0-17	20	0	0-56	102	3	2-11	119	1	0-7
SUNNYSIOE GENERAL HOSPITAL SUNNYSIOE WA 98944	2	50	0-91	6	17	7-72	21	10	3-33	.	.		67	3	1-14	32	0	0-22	6	0	0-97	32	6	1-21	25	4	0-30
SWEDISH HOSPITAL MEDICAL C SEATTLE WA 98104	58	24	9-40	30	37	22-58	161	12	5-16	64	0	0-23	388	6	4-10	214	2	1-10	75	0	0-26	389	8	3-8	675	1	0-3
TACOMA GENERAL HOSPITAL TACOMA WA 98405	13	23	8-58	21	29	19-61	104	9	4-17	3	0	0-98	226	10	3-10	114	4	1-12	35	3	0-82	313	7	3-8	276	1	1-5
TRI-STATE MEMORIAL HOSPITA CLARKSTON WA 99403	3	0	1-83	.	.		16	6	1-35	2	0	0-100	35	9	1-20	24	0	0-30	15	0	0-99	34	3	1-19	53	0	0-15
UNITED GENERAL HOSPITAL SEDRO WOOLLEY WA 98284	5	20	2-71	2	0	6-94	34	15	4-27	4	0	0-100	67	9	2-14	21	0	0-31	8	0	0-100	55	7	2-15	68	6	0-10
UNIVERSITY HOSPITAL SEATTLE WA 98195	20	15	3-44	6	33	9-75	14	7	1-38	52	0	0-21	51	8	1-16	35	3	1-22	9	0	0-69	392	9	4-9	133	0	0-6
VALLEY GENERAL HOSPITAL MONROE WA 98272	2	0	1-90	.	.		11	0	1-45	.	.		26	15	1-25	9	0	0-56	.	.		21	14	1-28	17	12	0-44
VALLEY HOSPITAL & MEDICAL SPOKANE WA 99216	5	20	4-74	7	29	10-73	40	5	3-23	1	0	0-100	147	6	2-10	74	0	2-15	4	0	0-100	76	5	2-13	96	2	0-8
VALLEY MEDICAL CENTER RENTON WA 98055	15	13	8-55	13	31	13-63	55	11	3-20	3	0	0-100	146	6	2-10	69	1	0-15	14	0	0-99	112	5	2-10	190	4	0-5
VANCOUVER MEMORIAL HOSPITA VANCOUVER WA 98663	.	.		2	100	8-96	25	4	4-31	2	0	0-100	46	7	1-17	13	8	0-51	26	0	0-96	44	2	1-17	35	0	0-20
VIRGINIA MASON HOSPITAL SEATTLE WA 98101	47	11	4-36	5	40	9-80	38	11	3-24	31	0	0-72	270	4	4-11	139	1	1-11	32	0	0-64	290	3	3-8	244	0	0-5
WALLA WALLA GENERAL HOSPIT WALLA WALLA WA 99362	6	17	1-66	4	25	8-83	29	10	2-26	7	0	0-100	66	3	2-15	19	0	0-57	7	0	0-100	30	0	1-21	47	4	0-17
WEST SEATTLE COMMUNITY HOS SEATTLE WA 98126	3	0	4-85	5	20	7-76	22	9	2-30	3	0	0-100	37	0	1-20	24	0	1-27	1	0	0-100	36	0	1-20	50	2	0-13
WHIDBEY GENERAL HOSPITAL COUPEVILLE WA 98239	2	0	1-90	3	33	6-87	18	11	2-34	2	0	0-100	55	2	1-15	41	5	0-22	9	0	0-100	31	10	1-21	21	5	0-42
WHITMAN COMMUNITY HOSPITAL COLFAX WA 99111	1	0	0-99	5	40	8-78	6	33	2-63	.	.		23	4	1-26	13	0	1-40	1	0	0-100	19	5	1-30	10	0	0-85

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		High Risk Diagnostic Categories																											
		Overall			Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WILLAPA HARBOR HOSPITAL SOUTH BEND WA 98586	WA-115*	199	18	10-21	9	78	18-76	10	30	9-61	5	0	1-68	8	13	5-61	11	64	19-72	9	11	3-55	33	18	11-40
YAKIMA VALLEY MEMORIAL HDS YAKIMA WA 98902	WA-116	1872	11	9-16	192	24	18-34	63	30	17-40	38	11	6-32	70	20	15-36	70	49	29-53	25	12	10-44	143	22	15-31

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WILLAPA HARBOR HOSPITAL SOUTH BEND WA 98586	6	17	1-66	.	.		2	50	0-98	.	.		13	0	1-39	7	14	1-58	1	0	0-100	26	8	1-23	6	0	0-82
YAKIMA VALLEY MEMORIAL HOS YAKIMA WA 98902	13	8	6-54	17	35	14-59	64	9	5-21	8	0	0-100	143	8	3-11	138	1	1-11	43	0	0-32	96	4	2-12	168	1	0-6

*Written Comments Not Submitted.

auburn general hospital

where caring is part of the cure

October 23, 1987

To Whom It May Concern:

The following information for Auburn General Hospital is to be attached to the HCFA mortality report from the period of December 1, 1985 to January 30, 1987 prior to public disclosure.

The Medical Staff of Auburn General Hospital has, for many years, reviewed the medical records of every patient who expires in our hospital to assure the highest quality care is being given. Even though Auburn General fell within the expected mortality range for our hospital (15%), we would like to share the following comments regarding some of the specific diagnostic categories:

Urologic Disease-13% Predicted Range 1-15% Total number of deaths - 8
The review of deaths in Urologic Disease, while still within the expected range, show that the deaths are not related to urological procedures performed, but rather to other factors including overwhelming infections, diabetes, hardening of the arteries, and other diseases associated with patients in advanced years.

Renal Disease-40% Predicted Range 6-60% Total number of deaths - 4
The review of deaths in Renal (kidney) Disease show that 3 of the 4 patients suffered from chronic kidney failure as well as several other terminal conditions. These patients either elected against kidney dialysis or were not eligible for dialysis because of their other terminal conditions.

Low Risk Heart Disease-15% Predicted Range 1-11% Total number of deaths-13
Review of the deaths in Low Risk Heart Disease showed that 4 of the 13 charts were miscoded. Because of their known severe underlying disease, 5 of the 9 remaining patients had death with dignity (i.e., "No Code") as per the request of the patient or their family. The rights of the patient and their family are respected by our hospital staff when requests for no vigorous resuscitative measures are requested.

Mortality review is one of the ongoing processes of the Quality Assurance Program at Auburn General Hospital. It is one of many ways in which we can assess the high quality care which our patients have come to expect from Auburn General Hospital.

Sincerely,

Bruce J. Wandler M.D.
Bruce J. Wandler, M.D.
Chief of the Medical Staff

Michael M. Gherardini
Michael M. Gherardini
Managing Director

BJW/MMG/jj

20 second street n.e. auburn, washington 98002 • (206) 833-7711

BALLARD COMMUNITY HOSPITAL

October 26, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to review the data on our hospital mortality rates and to respond before the release of that data.

We appreciate your foresight in acknowledging the limitations of our data and in directing hospitals and the public not to use this data for making judgments about the quality of care in an individual hospital or in making comparisons among hospitals.

As shown in the statistics for our hospital, we fall within your range of predicted mortality rates in all categories reported. We wish to note that 26% of the patients included in our statistics died outside the hospital. No data was provided as to the cause of death, just that these patients had been hospitalized within the previous 30 days.

The Board of Directors, Medical Staff and Administration of Ballard Community Hospital have always had a commitment to the delivery and assessment of excellent patient care. The medical staff has an ongoing process of monitoring the quality and appropriateness of the care we provide. All patients admitted to Ballard Hospital have their care reviewed for outcome, and mortality is one important aspect that is assessed on a continual basis. In fact, this peer review process was recently reviewed by the Joint Commission on Accreditation of Hospitals and commended by our physician surveyor.

Again, thank you for the opportunity to respond.

Sincerely,

Thomas W. Malone
Board Chairman

William Phillips, M.D.
Chief of Staff

Paul LeBrun
Acting Administrator

NW Market and Barnes
Box C-70707
Seattle, WA 98107-1507
(206) 782-2700

CASCADE VALLEY HOSPITAL

Snohomish County Hospital District No. 3

Mrs. Esther M. Wright, Commissioner
William Roal, Commissioner
Robert M. Williams, Commissioner
Mary Ellen Willie, Administrator

330 S. Stillaguamish St.
Arlington, Washington, 98223
Phone: 435-2133

October 1, 1987. PROVIDER NUMBER 500060

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Finance Administration
Washington D.C., 20201

Dear Sir:

I need to draw your attention to the inaccurate number of admissions ascribed by HCFA to Cascade Valley Hospital for 1986. The number of cases for each category is also presumptively incorrect.

Please note the following incomplete list of corrections:

Actual Medicare admissions 1986 = 577 (Deaths 55) Mortality rate 10%
HL - 34 patients, 3% mortality rate
HM - 44 patients, 14% "
HS - 53 " 26% "
SE - 8 " 25% "

If we can be of further assistance, please advise.

Following are some comments which might be included in the December publication:

1. The statistics provided by HCFA may not be accurate.
2. Some of the newer techniques for which a patient previously would have been transferred to another acute facility are now being used at CVH to manage patients presenting to the hospital with an evolving MI.
3. Our Quality Assurance program now has a built-in mechanism for better identification of problems, investigation, peer review and follow-up.
4. It must be remembered that with small hospitals of 50 beds or less, one death might represent in any given category a mortality rate of 25, 50, or even 100 percent.

This study is indeed a valiant undertaking. There are many variables, however, and one must question the real validity to these interesting statistics. How can the consumer, given this data, really be able to choose a hospital in which to be a patient?

Sincerely,

Ellen L. Spradley

Ellen L. Spradley, R.N., B.S.N.
Utilization/DRG Manager

WA 15

cc: Robert D. Campbell, Administrator

DEACONESS
MEDICAL CENTER·SPOKANE

West 800 Fifth Avenue

Post Office Box 248
Spokane, WA
99210-0248

(509) 458-5800

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Colleagues in Health Care:

Thank you for the opportunity to review and respond to Deaconess Medical Center's 1986 mortality data which is scheduled for release by HCFA in December of this year. Our Medicare provider number is 500044.

Deaconess Medical Center-Spokane is a 372-bed regional tertiary patient care facility and is one of the largest hospitals in the State of Washington. Patients are referred by their local physicians from throughout the Inland Northwest to receive specialized care at the Deaconess which includes cardiology; oncology; high-risk obstetrics; intensive care for infants, children and adults; medical/surgical services and pediatrics. Deaconess Medical Center provides an air ambulance service for transport of critically ill patients and has a highly specialized emergency department to receive trauma patients.

The mortality data has been reviewed by the President of the Medical Staff, Physician Chairman of the Utilization Management Committee, Director of Utilization Management, and the Director of Medical Records. Based on their review of this data and the specific medical records involved, the data is accurate, with minor exceptions.

The medical staff, hospital departments, and nursing service of Deaconess Medical Center participate in an ongoing quality assurance program designed to objectively and systematically monitor and evaluate the quality and appropriateness of patient care. A review of all deaths at Deaconess is performed by each medical staff department.

To help make the data more meaningful, we provide the following profile.

Diagnostic Category-Severe Trauma

The range of predicted mortality rates in this category was 5 to 21% and ours was 8%. More detailed information includes:

--The average age for these patients was 81 years old.
--Four patients had multiple chronic medical problems prior to the incident of trauma.
--Three patients had a previous history of carcinoma and chemotherapy.
--One patient suffered a cardiac arrest on the fourth post operative day and did not respond following aggressive resuscitative measures.
--Two deaths occurred during the post hospital period.

Diagnostic Category-Cerebrovascular Accidents

The range of predicted mortality rates in this category was 17 to 41% and ours was 30%. More detailed information includes:

--The average age for these patients was 80 years.
--Six patients were comatose at the time of admission.
--Eight patients were treated with supportive rather then aggressive case management at the request of the patient and/or family.
--All patients in this category suffered from multiple disease processes and/or co-morbid conditions.

Diagnostic Category-Severe Chronic Heart Disease

The range of predicted mortality rates in this category was 17 to 33% and ours was 24%. More detailed information includes:

--Patients in this category reflect one of the major services of our facility-cardiovascular.
--The average age for these patients was 77 years.
--Fourteen deaths occurred during the post-hospital period.
--Eleven patients were acutely ill at time of admission and were admitted through the emergency department.
--Two patients were admitted from skilled nursing facilities for acute hospital care.
--Eight patients had a history of a previous myocardial infarction (heart attack).
--Four patients had an underlying malignancy.
--One patient left against medical advice.

If additional information is desired, please feel free to call.

Very Truly Yours,

Thomas J. Zellers
President

EVERGREEN
HOSPITAL
MEDICAL
CENTER

King County Hospital District No. 2
12040 N.E. 128th Street
Kirkland, Washington 98034
206-821-1111

October 2, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O.Box 26684
Baltimore, Maryland 21207

Dear Sir:

Attached you'll find the comments requested to be included in the December 1987 HCFA mortality data report.

Sincerely,

James M. Good
Chief Operating Officer

cc: Andrew Fallat, FACHE
Ellie Fischer

EVERGREEN
HOSPITAL
MEDICAL
CENTER

King County Hospital District No. 2
12040 N.E. 128th Street
Kirkland, Washington 98034
206-821-1111

October 2, 1987

The HCFA statistical analysis is simply an attempt to make hospital mortality rates more comparable by holding constant selected factors that can be identified and measured using data available from current Medicare claims files. What is provided by HCFA is a statistical model which attempts to measure the relationship between a limited number of patient characteristics and the risk of death. Whether the factors identified by HCFA influencing the risk of death are the most significant factors in reality is not known. The HCFA data are not, in themselves, measures of hospital performance and under no circumstances should they be used as the basis for judging the quality of care provided by hospitals.

James M. Good
Chief Operating Officer
Evergreen Hospital Medical Center
King County Public Hospital District No. 2

The Fifth Avenue Medical Center

10560 – 5th Avenue N.E. Seattle, WA 98125-0977 (206) 364-2050

October 1, 1987

HSQB: ACTION
CC: Somsak; Jones; Greif

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

DIRECT REPLY DUE 11/6

Medicare Provider #50-0075

Dear Sir:

I am writing in response to your letter of September 21, 1987, in which you present mortality information about Medicare patients treated in our hospital in 1986.

It is noted that our overall actual mortality rate for the above referenced patients was only 8%, while the predicted range ran from a low of 7% to a high of 17%.

I would like to comment about our mortality rate for cancer patients. Three cancer patients with Medicare status were admitted to our hospital; one died in the hospital, one died within 30 days of discharge and one was alive 30 days after discharge. The average age of the two patients who died was 78.

Our hospital does not normally treat cancer patients. Cancer patients are normally referred to local tertiary centers who provide radiation and chemotherapy treatment. The two patients who died were terminal cases who were admitted for symptomatic and supportive care. Their families desired no further treatment of an interventional nature.

Thank you for this opportunity to comment on the mortality statistics.

Sincerely,

Albert R Yonck

Albert R. Yonck
Hospital Director

ARY:ml

cc: WSHA

GOOD SAMARITAN HOSPITAL

October 27, 1987 Medicare Provider #50-0079

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for allowing us to comment on Good Samaritan Hospital's selected mortality data for Medicare patients treated in our facility in 1986. Since receiving this information, the data has been carefully reviewed by hospital administration, the president of our medical staff, the physician chairmen of the Quality Assurance and Utilization Review Committees, the director of medical records and our quality assurance and utilization review coordinators.

Good Samaritan Hospital's percentage of deaths is within the predicted range that HCFA established for each of the 16 diagnostic categories your agency examined. Our overall mortality rate is also within HCFA's predicted range and is below our state peer group and Washington statewide averages.

The hospital's medical staff routinely conducts intensive reviews of medical records of patients who expire in our facility. This mortality review is an integral component of our quality assurance and peer review activities designed to ensure that care is appropriate and state-of-the-art services are delivered. This was reinforced by our Spring, 1987 Joint Commission on Hospital Accreditation visit when the physician reviewer concluded that Good Samaritan's quality assurance program ranks as one of the best in the country.

Thirty-nine percent of the Medicare mortalities associated with Good Samaritan occurred after the patients were discharged, and these deaths are included in our mortality rate. An unlikely, but possible circumstance that could occur and still count in our rate, is if a patient was discharged from the hospital and hit by a truck while crossing the street. We develop a comprehensive discharge plan for all of Good Samaritan Hospital's inpatients. This plan considers the patient's age,

GOOD SAMARITAN COMMUNITY HEALTHCARE
407-14th Avenue S.E.
P.O. Box 1247
Puyallup, Washington 98371-0192
(206) 848-6661

socio-economic status, social support system, health status and health history so that each patient is discharged to an environment that best meets his or her individual needs. To ensure continuity of care, we have established positive working relationships with all of the area nursing homes and our organization offers a variety of post-acute care services described below.

Good Samaritan Hospital and Rehabilitation Center operates a broad range of alternative delivery services. Our continuum of care includes a variety of services that attract "high risk" patients, such as oncology, major orthopedic services, pulmonary services, intensive and critical care, cardiology, gastroenterology and 24-hour emergency services. We operate the only hospital in East Pierce County, Washington, serving approximately 185,000 residents. In addition, Good Samaritan offers comprehensive inpatient and outpatient rehabilitation services for stroke, spinal cord and head injury, serving patients from throughout the Pacific Northwest.

We are recognized as a leader in older adult services, which have been established in response to the needs of the communities we serve. Our older adult services include home health, hospice, adult day health, mental health, respite services, senior case management, geriatric evaluation and assessment, and senior information and referral. Our delivery system cares for most of the older adults who reside in our service area. In addition to East Pierce County, we provide these non-traditional services to seniors residing throughout Pierce (including Tacoma and Gig Harbor), Kitsap, and South King Counties.

Both our rehabilitation and older adult services serve frail, physically and mentally disabled individuals from a broad area in Washington. As a result, we care for many individuals during the latter part of their lives. This type of information, coupled with factors such as cause of death and severity of illness would increase the validity of your model and better explain the difference in hospital mortality rates.

Good Samaritan Hospital and its medical staff will continue to review all mortality cases for quality and appropriateness of care rendered to individual patients. This endeavor assists us in identifying opportunities where we can improve the manner in which we care for patients. Thank you for allowing us to respond to your analysis. If you need additional information, please do not hesitate to contact me.

Sincerely,

David K. Hamry, FACHE
President

cc: Charles Jacobson, M.D.
Medical Staff President

GOOD SAMARITAN HOSPITAL
PUYALLUP, WA

SELECTED 1986 MORTALITY DATA
SUMMARY OF CORRECTIONS

Attachment	Content
I.	Revised Summary Table
II.	Patients Not Admitted During 1986 Or Transferred To Another Acute Care Facility
III.	Principal Diagnoses Corrections
IV.	Date of Expiration Corrections
V.	Patient Age Corrections

ATTACHMENT I

REVISED SUMMARY TABLE

Diagnostic Category	Cases	Actual Mortality Rate	Range of Predicted Mortality Rates
All Causes	1,786	11.8 %	8 to 15 %
CA - Cancer	85	24.7 %	13 to 34 %
CE - Cerebrovascular Accidents	54	29.6 %	17 to 41 %
EY - Ophthalmologic Disease	1	0 %	0 to 100 %
GC - Gastrointestinal Catastrophes	68	25.0 %	9 to 30 %
GI - Gastrointestinal Disease	126	6.4 %	3 to 13 %
GU - Urologic Disease	77	2.6 %	1 to 14 %
GY - Gynecologic Disease	19	0 %	0 to 57 %
HL - Low-Risk Heart Disease	111	2.7 %	2 to 10 %
HM - Severe Chronic Heart Disease	103	13.6 %	14 to 30 %
HS - Severe Acute Heart Disease	56	42.9 %	25 to 51 %
ME - Metabolic/Electrolyte Disturbances	50	24.0 %	13 to 39 %
OP - Orthopedic Disorders	146	0.7 %	0 to 6 %
PN - Pulmonary Disease	172	24.4 %	13 to 27 %
RN - Renal Disease	12	8.3 %	5 to 55 %
SE - Sepsis	13	7.7 %	14 to 64 %
TR - Severe Trauma	50	12.0 %	3 to 21 %

ATTACHMENT II

PATIENTS NOT ADMITTED DURING 1986
OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY

A. The following 1985 admissions were erroneously included in the HCFA Mortality Data Release for patients admitted to GSH in 1986.

HIC #	Patient	Admitted	Discharged
[redacted]		12/28/85	01/09/86
		12/29/85	01/10/86
		12/29/85	01/03/86
		12/24/85	01/11/86
		12/29/85	01/13/86

B. No Record of Patient at GSH

The HCFA death list shows [redacted], 86 y/o female, admitted 11/25/86, discharged 11/26/86, died 11/27/86.

This patient was not admitted to GSH on the dates indicated above. We have no record of any admission for a female, age 86, last name Long, in 1986

C. Patients Transferred to Another Acute Care Facility

[redacted] 58 y/o male, admitted 02/09/86, discharged 02/09/86, died 02/09/86. This patient was discharged alive, transferred to Veterans Administration Hospital in Seattle. Death occurred at that hospital (Category HS).

[redacted], 69 y/o male, admitted 04/02/86, discharged 04/03/86, died 04/30/86. Transferred alive to VA Hospital in Seattle (Category GI).

[redacted] 89 y/o male, admitted 02/19/86, discharged 03/03/86, died 03/21/86. Transferred alive to VA Hospital in Seattle (Category PN).

[redacted] 65 y/o male, admitted 09/12/86, discharged 09/18/86, died 09/21/86. Transferred alive to VA Hospital-American Lake (Category PN).

ATTACHMENT III

PRINCIPAL DIAGNOSES CORRECTIONS

HIC #	Name	PDX Error	PDX Correction
[redacted]		174.9	276.7
[redacted]		436	410.4
[redacted]		560.1	428.0
[redacted]		428.0	174.9
[redacted]		425.4	428.0
[redacted]		428.0	410.1
[redacted]		276.5	198.3
[redacted]		733.00	789.0
[redacted]		511.9	480.9
[redacted]		493.90	496
[redacted]		496	466.0
[redacted]		799.1	486
[redacted]		466.0	162.9

ATTACHMENT IV

DATE OF EXPIRATION CORRECTIONS

HIC #	Patient Name	Admitted	Discharged	Expiration Date Error	Expiration Date Corrected*
[redacted]		11/25/86	11/26/86	11/27/86	11/26/86
[redacted]		03/04/86	03/19/86	03/21/86	03/19/86

* Both expirations occurred in the hospital, not post-discharge.

ATTACHMENT V

PATIENT AGE CORRECTIONS

HIC #	Patient Name	AGE	
		Error	Correction
[redacted]		74	71
[redacted]		78	79
[redacted]		77	78
[redacted]		72	74



October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

The following information for Grays Harbor Community Hospital is to be attached to the Hospital Specific Report for the period December 1, 1985, through January 30, 1987, prior to public disclosure.

Grays Harbor Community Hospital is a 96 bed acute care facility, whose case mix includes many patients with both medical and surgical illnesses. We are a full service hospital offering care in specialty areas of oncology, obstetrics and emergency services, as well as general medicine and surgery.

The Medical Staff of Grays Harbor Community Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an ongoing process of the Quality Assurance program, and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital. The Joint Commission on Accreditation of Hospitals bestowed on this facility its highest commendations in the form of a three-year accreditation for the hospital Quality Assurance program and the excellent peer review process that is performed. Our JCAH accreditation has spanned 24 years without interruption.

The hospital specific mortality data reported by HCFA has been carefully reviewed by the Hospital Administrators, President of the Medical Staff, the Quality and Utilization Review Committee, and the Director of Medical Records. Our overall percentage of deaths is well within the statewide average.

Regarding gynecologic disease, it should be noted there is insufficient data to predict a range.

Regarding sepsis, the range of predicted death rates is 6 to 81%. Of the very small sample of patients with this diagnosis, our actual death rate was 75%. It should be noted that all patients were diagnosed as having end-stage renal failure.

Of note, this data release includes cumulative data for the period December 1, 1985, through January 30, 1987. Most of the data includes previously released information, but this time it appears in a different format. The previous data release was by Major Diagnostic Category, and this release is by Diagnosis Related Group. As previously stated, review by this facility is always by individual case regarding overall quality of care, and is conducted in an ongoing fashion, not just when statistics such as the mortality data are released.

Thank you for the opportunity to present this response.

Sincerely,

Mark F. Hawkins
Assistant Administrator/General Services

Ann Monaghan, RN

Ann Monaghan
Assistant Administrator/Patient Services

John Sherrett

John W. Sherrett
Assistant Administrator/Fiscal Services

MFH/AM/JWS/ec

Harborview Medical Center
325 NINTH AVENUE
SEATTLE, WASHINGTON 98104
206/223-3000

October 27, 1987

Dr. William L. Roper, Administrator
c/o Mr. Harvey Brook
Health Standard and Quality Bureau
Room 2D2
Meadow East Building
6300 Security Blvd.
Baltimore, MD 21207

Re: Hospital Specific Mortality Data

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of mortality information about Medicare patients treated at Harborview Medical Center in 1986.

It is important to note that Harborview is a Level I Trauma Center and a Regional Referral Center, providing care for the most critically ill and injured patients from an area that includes Washington, Alaska, Montana and Idaho. Our patients include burn, trauma and critical care patients, many with multiple medical problems. In addition, Harborview cares for many medically indigent patients who delay seeking care until their health problems have become critical.

Data Accuracy
The Health Care Financing Administration (HCFA) hospital specific mortality data has been determined to be generally accurate with minor exceptions.

The information was reviewed by our Quality Assurance Department, the Infection Control Service, Patient Data Services, Medical Director and Hospital Administration.

Overall Mortality Rate
Harborview Medical Center is reported as being within the range of predicted mortality rates from all causes as reported by HCFA.

Diagnostic Category Specific Mortality Rates
Harborview Medical Center is reported to be within the range of predicted HCFA mortality rates for thirteen (13) of the (16) diagnostic categories reported, notwithstanding the severity of our patients'illnesses and injuries. For the three (3) categories where actual mortality rates were higher than the predicted rates, our review showed the following:

Cerebrovascular Accidents (Strokes)
The predicted HCFA range of deaths for strokes was found to be 15 to 40 percent while Harborview's rate was 46 percent. The average age for the 23 Harborview patients included in this category was 74.4 years. Nine of the patients were referred from other institutions in critical condition and seven patients were unresponsive or comatose on admission and had no chance of returning to any cognative function. In addition, these patients had complicating conditions including cancer and pneumonia. Our review indicated that given the severity of condition, age and circumstance of the patients, the rate was expected.

Sepsis (Overwhelming Infection)
The predicted range of deaths for infection was found to be 15 to 75 percent while Harborview's rate was 88 percent. The average age for the seven HMC patients in this category was 76.6 years. Six of these patients were admitted to Harborview from other institutions (nursing homes) with infection, sepsis and terminal pneumonia present prior to admission. In addition each of these patients had other complicating problems, such as diabetes, stroke, high blood pressure or dementia. The remaining patient, admitted for terminal cancer, had refused treatment for his lung and brain cancer on previous admissions as well as this last one. Our review indicated that given the severity of condition, circumstances and age of the patients, the higher mortality rate is explainable.

Severe Trauma
The predicted range of deaths from severe trauma was found to be 3 to 20 percent while Harborview's reported rate was 22 percent. The average age for the 13 patients in this category was 77.5 years. Three of the patients in this category were admitted with extensive burns ranging from 60 to 99 percent of total body area. The mortality rate for burns as extensive as these is 100 percent according to the National Burn Information Center. Two of the patients were involved in motor vehicle accidents and sustained fatal injuries . Two were assault victims and two were successfully attempted suicides. The remaining patients were fall victims who sustained massive internal head injuries. Our review concluded that given the extent of injuries, age and circumstances of the patients that the rate was not unusual.

The inclusion of severity-of-illness is one important element currently missing from this particular index. We urge the continued efforts to refine the methodology if HCFA is to continue to use this index.

Thank you for the opportunity to respond to this release of data.

Sincerely,

David W Gitch

David W. Gitch
Administrator

lbr:COR1:053

HIGHLINE COMMUNITY HOSPITAL
16251 Sylvester Road S.W. / Seattle, WA 98166 / (206) 244-9970

October 26, 1987

Harvey Brook
HCFA
Department of Health and Human Services
Attn: HS-148-GNC
P.O. Box 26676
Baltimore, Maryland 21201

Dear Mr. Brook,

Thank you for the opportunity to respond to the HCFA mortality data. Highline Community Hospital is dedicated to quality patient care. We support the consumer's right to access information which assists them in making responsible health care decisions, and we encourage the development of information to achieve this end.

Highline Community Hospital is a 154-bed, full-service hospital offering several specialized programs including cancer, cardiac, and stroke treatment as well as general medical and surgical services. We have a special commitment to serving the elderly population in our community.

The mortality data has been validated by the director of medical records and with few exceptions is essentially accurate. Hospital administration and medical staff committees, including quality assurance and utilization review, have also reviewed the data. It is noted that Highline Community Hospital is within the hospital specific predicted range in all sixteen categories. It is also significant to note that Highline Community Hospital is below the mean in ten of the sixteen categories.

Highline Community Hospital's quality assurance program is approved by the Joint Commission on Accreditation of Hospitals and includes ongoing mortality review. The top priority is examination of quality and appropriateness of care. The medical staff routinely reviews all deaths as well as infection rates, blood utilization, drug utilization, complications, and unexpected outcomes.

The HCFA mortality data review gave us additional information to look at deaths occurring following hospital discharge. What we learned confirms our commitment to discharge planning with appropriate in-home assistance. Our study also revealed some of the limitations of the data collection method. Our sole death in the ophthalmology category was a patient who died at home of an unrelated condition on day 29. A cursory look at the data could never reveal that information.

We appreciate the opportunity to present this response.

Sincerely,

Paul Tucker
Administrator

HOLY FAMILY HOSPITAL
North 5633 Lidgerwood • Spokane, WA 99207 • 509/482-0111

October 26, 1987

William L. Roper, M.D., Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to your report received September 24, 1987 regarding hospital mortality rates of Medicare patients for the year 1986.

Holy Family Hospital is a 228-bed community hospital providing a full range of hospital services for treatment of major illness or trauma. The hospital's medical staff reviews hospital services and medical care provided for all Medicare patients. As part of our quality assurance program, an intensive review of the care of every patient whose life comes to an end during hospitalization is always performed. The data provided in this governmental report indicates the number of deaths occurring from all causes in Holy Family's Medicare patients is not unusual, and falls well within the range of normal occurrence.

The report has some limitations which should be noted. The statistical model used by HCFA does not include measures of severity (that is, how ill the patient was at time of admission), whether the patient was transferred from a nursing home, whether the patient was receiving treatment at home prior to admission, and whether the patient had a terminal illness. The American Hospital Association has pointed out that mortality data does not identify quality nor otherwise measure hospital performance. The comparison of actual and predicted mortality rates only suggests areas to be reviewed to determine if there are any quality of care issues.

The data showed there were no diagnostic categories, at Holy Family, in which the number of deaths exceeded the predicted mortality rates. The medical staff, however, studied the report and is in the process of reviewing those deaths occurring in four diagnostic groupings where the number fell in the higher end of the range. All are being individually reviewed again by qualified physicians, including specialists in each area. To date there are no instances where quality of care is an issue.

Also, of the 257 Medicare deaths in 1986, 67 of these patients were no longer hospitalized and expired outside the hospital setting for reasons which may, or may not, have been related to their reason for being hospitalized. The medical staff reviewed these patient's hospital records and determined none of these patients were prematurely discharged.

In addition to this comprehensive review, Washington Peer Review Organization (PRO/W), who is responsible to the Federal Government for reviewing quality of care for Medicare patients, also conducted a similar review. At this time, PRO has completed a review of the majority of patient deaths included in this report and reported no significant concerns regarding quality of care.

The hospital and the medical staff are dedicated to providing a high quality of care to all patients, and the public is assured that review of quality and appropriate care will always be an on-going process at Holy Family Hospital.

Sincerely,

Michael D. Wilson
President

Lyle E. Crecelius, M.D.
President, Medical Staff

MDW:mjj

South 19th and Union
PO Box 11414
Tacoma Washington
98411-0414
Telephone 206 572-2323

Humana Hospital Tacoma

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26614
Baltimore, Maryland 21207

Dear Sirs:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Tacoma supports the Health Care Financing Administration's desire to educate those interested in healthcare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

We intend to utilize the HCFA's mortality data as an integral part of our hospital's quality assurance program. Currently our QA program includes regular and complete review of all admissions which result in patient mortality and is further subject to outside review by JCAHC.

We believe the statistical significance of the raw numbers is somewhat suspect in that they reflect deaths which occurred in only a limited segment of the hospital's patient population (i.e. the elderly) and are not adjusted for severity of illness or other factors which may have affected patient outcome. Because of these factors, consumers should be cautioned about judging the quality of a hospital based solely on mortality data.

Our hospital's medical records department and our QI manager have reviewed the mortality data. In that several deaths occurred outside the hospital we cannot validate the data with complete certainty. Generally the data was found to be consistent with our records. We did, however, find two errors, (i.e. one patient was apparently never a patient in our hospital and one patient's date of death was listed as 4/3/86 when it should have been 4/2/86). Again we would submit that in most cases the number of patients in each category was too small to produce data with a high level of statistical significance.

Mortality Information - Humana Hospital, Tacoma

Hopefully our response will assist you in further refining your efforts to produce improved mortality data in the future. We will continue to support HCFA's efforts to this end and assist our community in understanding the significance of mortality statistics and how they may be used in the future to improve health care services.

Sincerely,

Sharon Armstrong

Sharon Armstrong
Executive Director

SA:lms

ISLAND HOSPITAL

October 21, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Please include this response along with the 1986 HCFA Mortality Statistics for Island Hospital that you will be publishing in the December 1, 1987 Federal Register. Our response is as follows:

Mortality data are one of the indicators used to guide or focus peer review at Island Hospital. Quality of care is of the utmost concern to Island Hospital's governing board, administration, and medical staff. Any indication of potential quality problems, including mortality data, are promptly investigated to determine if in fact, a problem exists. Quality care can only be evaluated through this process of peer review, which examines the entire medical record, not just through simple statistical comparisons. Any questions or concerns you may have in regard to these statistics, are welcome and can be directed to Vicki Holte,RN, Quality Assurance Coordinator, (206) 293-3181, extension 308, Island Hospital, Anacortes, WA.

Sincerely yours,

C. Philip Sandifer, Administrator

Lawrence Becker, M.D., Chief of Staff

24TH STREET AND M AVENUE, ANACORTES, WASHINGTON 98221, (206) 293-3181

KADLEC MEDICAL CENTER

Medicare Provider #: 500058

COMMENTS ON HCFA MORTALITY DATA - 1986

The data used by HCFA indicates 894 Medicare patients were admitted to Kadlec Medical Center with 110 dying within 30 days of admission. Our own records show 1406 Medicare admissions occured in 1986 with 77 deaths. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to the hospital and patients who died after being discharged from Kadlec Medical Center.

We have verified that, in addition to the 77 patients who died while still a patient at our facility, the remaining 33 reported deaths were for patients who were hospitalized at Kadlec Medical Center at least once during 1986. It is impossible to determine whether any of these 33 patients are in fact alive, as information concerning deaths after discharge is not included in the patient's hospital medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the analysis. We do note that the patients were grouped into diagnostic categories based on principal diagnosis and procedure. This may not always accurately reflect the actual cause of death.

Kadlec Medical Center's actual mortality rate falls outside the range of predicted mortality rate in only one category - RN/Renal Disease. In this group we had a 0% mortality rate. This may be attributed to the fact that renal dialysis services are not available at our facility and patients in acute renal failure must be transferred outside the area.

Other similar factors involving availability of services may influence mortality rates in a number of ways.

Finally, we must emphasize that the HCFA data are not, in themselves, measures of a hospital's performance or its quality of care. The model used to calculate predicted mortality rates appears to have limited reliability and has not been validated. The includion of patients who died after discharge from a hospital may result in the attribution to that hospital of deaths that are unrelated to the condition for which the patient was under treatment at the time of discharge or that resulted from postdischarge care that was outside the scope of hospital services.

Jon R. Dawe

888 SWIFT BOULEVARD / RICHLAND, WA 99352 / 509-946-4611

KGH
Kennewick General Hospital
900 South Auburn, P.O. Box 6128, Kennewick, WA 99336
Tel. 509/586-6111

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore, MD 21207

Gentlemen:

Kennewick General Hospital has received the mortality predictions based on Medicare patients treated in our hospital in 1986. We call attention to the fact that this study includes patients whose last hospital admission prior to death was to Kennewick General Hospital and whose death occurred within 30 days of that admission. In many instances, the death did not occur in the hospital, and in some instances, the cause of death was not related to the reason for hospitalization.

The director of Medical Records has validated that, with minor exceptions, the data are accurate. The hospital's medical staff actively reviews all mortality cases for quality and appropriateness of care given to the individual patients at Kennewick General Hospital.

The Health Care Financing Administration has established a range of predicted mortality rate from all causes of 9% to 17% for Kennewick General Hospital. The actual mortality rate as determined by HCFA for KGH was 14%. A breakdown by specific diagnostic categories revealed that the actual mortality rate fell within the range of predicted mortality rates except in two categories in which the actual was below the predicted.

Kennewick General Hospital will continue its long-established practice of reviewing the quality and appropriateness of patient care at every level of delivery -- the physician, the nurse, and the ancillay personnel.

Our goal continues to be to assure that the very finest care be provided to residents of the hospital district that we serve.

Sincerely,

Michael R. Fraser
Administrator

MF:j

KITTITAS VALLEY COMMUNITY HOSPITAL
PUBLIC HOSPITAL DISTRICT #1
603 SOUTH CHESTNUT ELLENSBURG, WASHINGTON 98926 509 • 962-9841

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: HCFA Mortality Rates
Medicare Provider #500110

Thank you for the opportunity to respond to the release of data on hospital mortality rates for December 1, 1985 through January 30, 1987.

Since receiving the report dated September, 1987, Kittitas Valley Community Hospital staff has had an opportunity to review the data. The Director of Medical Records has validated that, with minor exceptions, the data is accurate.

We are pleased to note that the statistics represent a figure lower than predicted rates in 16 of 17 categories. The one category that is reported to be higher represents one cerebrovascular accident (stroke) patient in the 14 month period.

Our hospital medical staff committees monitor every death in our facility on an on-going basis. We believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards.

We feel the data can provide us with additional information upon which to base our monitoring. We will continue to review all mortality cases for the quality and appropriateness of care given to the individual patient. This process is a constant endeavor to assist in identifying opportunities to improve patient care at Kittitas Valley Community Hospital.

Sincerely,

Robert Schwartz
Administrator

Kenneth A. Harris M.D.

Ken Harris, M.D.
Chief of Medical Staff

LAKEWOOD HOSPITAL

Our Dedication Continues

5702-100th Street S.W.
Tacoma, Washington 98499-0998
206-588-1711

October 23, 1987

William L. Roper, M.D., Administrator
Healthcare Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Doctor Roper:

The Board of Directors and Medical Staff at Lakewood Hospital appreciate the opportunity to submit comments with regard to the mortality data released by HCFA for the year 1986.

The data have been reviewed by the Director of Medical Records and found to be statistically accurate. The Chairman of the hospital-wide Quality Assurance Committee and President of the Medical Staff have reviewed individual case reports and submit the following comments.

Each Medical Staff department at Lakewood Hospital has a quality assurance (peer review) committee which reviews the medical record of each patient who dies. The record is reviewed by physicians who answer such questions as:

- Given the patient's condition on admission, was death anticipated?
- Was treatment appropriate?
- Were consultants requested appropriately?

The physician reviewers present cases for discussion at department meetings which are of particular interest, educational value and/or warrant full departmental discussion for any other reason. This process has been effective because all doctors in the departments participate in the peer review process, monitor and accept responsibility for the care of patients in their specialty areas.

Since receipt of the HCFA Mortality Data, all cases in the two categories where Lakewood Hospital is near the high range of the predicted mortality rate were re-reviewed and the following noted:

CEREBROVASCULAR ACCIDENTS

- Twelve patients died in the reporting period. They ranged in age from 73 to 90 years.
- Ten of the twelve patients (83%) had "no code" or "do not resuscitate" orders at the family's request.

- Four patients were admitted from nursing homes, and two others died within six hours of admission, despite aggressive treatment.

SEVERE ACUTE HEART DISEASE

- Eighteen patients died in hospital, and one was transferred to a DRG-exempt facility. Even though that facility has an acute medical ward, Lakewood Hospital is credited with the death because transfer to a DRG-exempt facility is defined as a "discharge" from the transferring hospital for purposes of the HCFA report.

- One patient was transferred to Lakewood Hospital from a DRG-exempt facility with an acute medical ward. The patient arrived in full code status and lived less than one hour after admission.

- Seventeen patients were treated by cardiologists; all but one patient had a history of prior treatment for heart disease or other severe complicating medical condition.

- Six patients died within four hours of admission, despite aggressive treatment.

- One patient had refused treatment at a DRG-exempt facility for another medical condition because of end-stage organic heart disease.

- One 94-year-old patient had previously refused treatment for severe heart disease known to have been present for one year.

Lakewood Hospital had a 4% Actual Mortality Rate reported for the ORTHOPEDIC DISORDERS category. This rate represented two patients, both of whom died after discharge from the hospital.

- One patient actually died of severe pulmonary disease. The "orthopedic condition" for which she was treated on admission to Lakewood Hospital was a compression fracture due to osteoporosis.

- The second patient was treated at Lakewood Hospital for back strain after a fall. She was transferred to a nursing home for care of other severe multi-system diseases.

Even though all reported cases have been reviewed by the medical staff in the past, the hospital-wide Quality Assurance Committee has recommended that the HCFA Mortality Data Report be used by the Medical Staff department quality assurance committees as part of their on-going, comprehensive evaluation of the quality of care provided.

The actual mortality rates for patients at Lakewood Hospital are reported to be well within the range of predicted rates in all other categories. These

results serve to reinforce the effectiveness of the Lakewood Hospital Quality Assurance Program presently in place and will provide a baseline for measuring future performance.

Sincerely yours,

Richard Vanberg
Administrator

Jay H. Winemiller, M.D.
President, Medical Staff

LINCOLN HOSPITAL DISTRICT NUMBER THREE

COMMISSIONERS
GERALD BOLENEUS, Reardan
CARL NELSON, Creston
VERNON BUMGARNER, Davenport
SUSAN A. ELS, Harrington
ORRIEN MORSE Davenport

THOMAS J. MARTIN, Administrator

Telephone 509-725-7101
Davenport, Washington
99122

October 26, 1987

50-0089 - MEDICARE PROVIDER NO.

LINCOLN HOSPITALS RESPONSE TO THE HEALTHCARE FINANCING ADMINISTRATION HOSPITAL SPECIFIC MORTALITY DATA FOR 1986:

Lincoln Hospital and Nursing Home is dedicated to the provision of high quality, neighborly healthcare. In keeping with this commitment, the hospital has developed and implemented a thorough Quality Assurance program. This program is hospital wide and fully endorsed by the governing board, physicians and the hospital staff. This Quality Assurance program was established in a continuing effort by the hospital to provide excellence in healthcare to the Lincoln County community.

Lincoln Hospital is well within the expected or "predicted range" of mortality for all diagnostic categories reported on the Healthcare Financing Administration Mortality Data Report. Some hospitals that excede this "predicted range" of mortality may do so because of the programs they offer and the severity of illness of the patients they treat and not becuase of quality problems.

Lincoln Hospital has always been committed to quality of care and will continue to emphasize quality throughout its future patient care practices.

Yours very truly,

Thomas J. Martin

Thomas J. Martin
Administrator

TJM:mmr

Mark Reed Hospital

October 22, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Mark Reed Hospital (Medicare provider number 500061) has received and reviewed the Medicare Mortality Data for 1986. With one exception (the one cancer patient who died), the actual mortality rates fall at either 0% or well within the low range of the predicted rates.

The physicians and staff at Mark Reed have a strong commitment to providing quality medical care to the community. We feel that the mortality data helps to confirm that the hospital is achieving that goal.

Sincerely yours,

Jean E. Roberts

Jean E. Roberts
Administrator

/jer

322 So. Birch Street, Post Office Box 28 • McCleary, Washington 98557 • (206) 495-3244
Owned and Operated by Grays Harbor County Public Hospital District No. 1

Memorial Hospital
Lincoln County Hospital District No. 1

502 E. Amende, Box 368
Odessa, Washington 99159
509/982-2611

COMMISSIONERS:
Margaret Iltz
Larry Iverson
Mary L. Kern
Geraldine Goetz
W.B. Zagelow

DONALD W. JAMES
Administrator

September 25, 1987

Provider #: 500080

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Gentlemen:

Memorial Hospital's total mortality rate is well within the expected range.

In the gastrointestinal disease categories, the rate is 100% due to the fact that the only patient admitted in each category expired.

Gastrointestinal catastrophy is a high risk category, therefore, there is a significant possibility of death. In addition, both these patients were under treatement for serious chronic conditions in which death, although not expected at the time of admission, was again a significant possibility.

Sincerely,

Carol Schott

Carol A. Schott
Interim Administrator

CAS/vsw

NORTHWEST HOSPITAL

1550 North 115th Street
Seattle, WA 98133 (206) 364-0500

COMMENTS ON THE HCFA MORTALITY DATA

NORTHWEST HOSPITAL 50 - 0001
SEATTLE, WASHINGTON

As requested, we have reviewed the mortality rates as published by HCFA. We have verified that each patient was admitted to the hospital on the dates listed. All percentages as calculated were accurate with the data provided.

Although Northwest Hospital is well within your predicted range of expected deaths, the quality standards set up at Northwest Hospital requires review on every death. This review will continue. Additionaly quality of care reviews are conducted daily while the patients are hospitalized.

During 1986, Northwest Hospital cared for 3,330 Medicare patients. Your data only gives us credit for 2,159 patients. This inflates the death rate to 11%.

Also included in the listing of 246 deaths were 75 patients who died after they were discharged in 1986. In reviewing these medical records, we found that 71% of these patients were placed in nursing homes when they were last discharged from the hospital. We did not attempt to verify that the patients had actually died, nor do we have any way of knowing what caused their death.

We also noticed that 3 patients in the above group of 75, were readmitted to Northwest Hospital in the first part of 1987 and died in the hospital. These patients will need to be excluded in your count for 1987 deaths or you will be counting deaths twice.

Thank you for allowing us to review and comment on the mortality data.

James Hornell

JAMES HORNELL,
EXECUTIVE DIRECTOR
NORTHWEST HOSPITAL

aks

Pacific County Hospital District
OCEAN BEACH HOSPITAL
Ilwaco, Washington 98624

COMMENTS ON THE HCFA MORTALITY DATA
OCEAN BEACH HOSPITAL
Ilwaco, Wa 98624

DATA VERIFICATION

All of the deaths indicated by HCFA are authenticated by our Medicare Record Review and we find that we are well within the range of HCFA Predicted Mortality Rates.

Donald W Stubsten

Donald W. Stubsten

Olympic Memorial Hospital

939 Caroline
Port Angeles, WA
98362

(206) 457-8513

Public Hospital
Dist. No. 2 of
Clallam County

October 22, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Thank you for the opportunity to respond to the release of hospital mortality rates for the year 1986. Olympic Memorial Hospital is a 126 bed general care facility, accredited by the Joint Commission on Accreditation of Hospitals and serving patients with major medical and surgical illnesses. The hospital has been designated a rural referral center and, as such, provides comprehensive medical and surgical services to both local patients and those transferred here by other hospitals. These services include orthopedics, ophthalmology, oncology, urology, and other specialty areas as well as general medicine and general surgery.

The data provided have been reviewed by the hospital administrator, Chief of the Medical Staff, Chiefs of Medical and Surgical Services, Utilization Review Committee, Chairman of the Medical Care Evaluation Committee, and the Coordinators of Quality Assurance and Utilization Review. We are pleased to note that Olympic Memorial Hospital statistics fall well within the predicted range for hospitals treating comparable patients.

In an effort to provide optimum care and services to our patients and be responsive to consumer concerns and cost containment efforts, this hospital and its medical staff have established a hospitalwide quality assurance and peer review program. This process includes physician review of the medical record of each patient who expires at this facility to assess medical management and overall care provided. Trending analysis from these reviews is part of the constant endeavor to assist in identification of opportunities to improve care.

Sincerely,

Allen Remington, Administrator

Reed A. Wendel, M.D., Chief of Staff

Othello Community Hospital
350 N. 14th
Othello, WA 99344
509-488-2636

October 23, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on our hospital mortality rates for January 1, 1986 to December 31, 1986. Since receiving the report dated September 21, 1987, Othello Community Hospital staff has had an opportunity to review the data.

The Medical Staff at Othello Community Hospital conducts an intensive review of the medical record of every patient who expires at this facility. Mortality review is an on-going process of the Utilization Review Committee and Quality Assurance Program.

The hospital specific mortality data reported by HCFA has been carefully reviewed by the Hospital Administrator, Chief of Medical Staff, Quality Assurance Chairman, Utilization Review Coordinator, Director of Nursing Services, and the Hospital Board of Trustees.

Because our facility is a small rural hospital and because we feel that our mortality rate is very low that summarizing our findings by the individual 16 diagnostic categories could result in breech of patient confidentiality.

HCFA reported 11 deaths for 1986. Othello Community Hospital reported 11 deaths for 1986. Below you will find an overall summary.

8 patients were over the age of 80.
2 patients were over the age of 70.
1 patient was over the age of 60.

10 patient/families requested NO CODE STATUS on admission.
7 patients expired at our facility.
4 patients expired outside our facility;
3 at a Long Term Care Facility.
1 at home.

All were admitted with guarded conditions.

All 11 patients had multiple prior admissions to our facility of critical natures.

Again, thank you for this opportunity to respond.

Sincerely,

Jerry Lane
Administrator

David P. Hofheins, D.O.
Chief of Medical Staff

cc; Othello Community Hospital
Quality Assurance Committee
Utilization Review Committee

Our Lady Of Lourdes
HEALTH CENTER

520 North Fourth Avenue
Post Office Box 2568
Pasco, Washington 99302
Telephone (509) 547-7704

October 27, 1987

William L. Roper, M. D., Administrator
Department of Health and Human Services
Health Care Financing Administration
P. O. Box 26684
Baltimore, MD 21207

RE: Our Lady of Lourdes Health Center
Provider #500023

Dear Dr. Roper:

Our Lady of Lourdes Health Center has reviewed the mortality information for Medicare patients treated in our Center in 1986. During our review of the data some discrepancies were noted and we are requesting that they be corrected prior to publication. These are noted on the attached page, along with additional comments we would like published with your report.

We must emphasize that the HCFA data are not, in themselves, measures of a hospital's performance or its quality of care. The Medical Staff of Our Lady of Lourdes actively reviews all mortality cases for quality and appropriateness of care given to the individual patients. The model used by HCFA to calculate predicted mortality rates appears to have limited reliability and has not been validated. The inclusion of patients who died after discharge from a hospital may result in the attribution to that hospital of deaths that are unrelated to the condition for which the patient was under treatment at the time of discharge, or that resulted from post-discharge care that was outside the scope of hospital services.

Thank you for the opportunity to review this report prior to publication, and for addressing the discrepancies and comments we have brought to your attention.

Sincerely,

Thomas Corley
Administrator

TC:kj

Our Lady Of Lourdes
HEALTH CENTER

520 North Fourth Avenue
Post Office Box 2568
Pasco, Washington 99302
Telephone (509) 547-7704

HCFA MORTALITY INFORMATION MEDICARE NUMBER 500023

1. CORRECTIONS TO BE MADE PRIOR TO PUBLICATION:

[redacted] Two patients are listed with this HIC number. The first patient listed was not a patient at Our Lady of Lourdes Health Center on this date. The second patient listed was a patient on 7/1/86 and did expire on 7/13/86. The HIC number for the second patient should be [redacted]

[redacted] Patient expired in the hospital on 9-29-86, not the day following discharge, 9-30-86 as stated in report.

[redacted] Patient expired in the hospital on 12-18-86, not two days following discharge on 12-20-86 as stated in report.

2. COMMENTS FOR PUBLICATION:

[redacted] Patient admitted for infection of the eye. Patient had previous history positive for hypertension, CVA, Myocardial Infarction, and Chronic Obstructive Pulmonary Disease. This 84 year old patient was discharged home with Home Health assistance and declined any further discharge planning assistance.

Twelve patients, or 18% of the Medicare patients who expired within 30 days of admission to Our Lady of Lourdes Hospital had been discharged or transferred. Fifty eight percent of these patients had been transferred to a Nursing Home setting. Twenty-five percent of these patients were discharged with Home Health, Hospice, and/or twenty four hour caregiver services arranged by the hospital Discharge Planner at the request of the patient and/or family. Seventeen percent of these patients and/or families were offered Discharge Planning Services by the hospital, however, declined any assistance.

Our Lady of Lourdes Health Center is pleased that the HCFA Mortality Report statistics indicate the actual mortality rate is below the range of predicted mortality rates established by HCFA.

OVERLAKE HOSPITAL MEDICAL CENTER

October 26, 1987

VIA FEDERAL EXPRESS

William L. Roper, M.D., Administrator
Health Care Financing Administration
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the HCFA Mortality Data Release for Overlake Hospital Medical Center.

The data has been carefully reviewed by our quality assurance staff, physicians and administration. We are pleased that our mortality rates for 1986 fall within the predicted ranges in each of the 16 categories.

We would like to take this opportunity to highlight one of the categories listed by HCFA -- Low Risk Gastrointestinal Disease. Our analysis revealed that the term "low risk" is not an adequate description of the patient population referred to in our 1986 statistics. The average age of our patients was 81.4 years, and over 53% of the patients were diagnosed as "terminal" upon admission to Overlake. Over 93% of the patients and/or their family members requested that life-extending measures not be pursued in the event of an emergency medical situation. Sixty percent of our patients had additional pre-existing complex diseases that the HCFA data system was not able to include in its analysis.

The medical staff at Overlake Hospital Medical Center, with the assistance of the quality assurance staff, conducts an intensive review of the medical records of every patient who expires at this hospital. Mortality review is an ongoing and vital part of our peer review system.

We salute HCFA's attempt to begin providing data that allows the public to be better informed about Overlake Hospital Medical Center and other health care providers in our community.

Sincerely,

Sanderson J. Jeghers
President and
Chief Executive Officer

SJJ/cla

PROVIDENCE CENTRAL MEMORIAL HOSPITAL
502 WEST 4th AVENUE
TOPPENISH, WASHINGTON 98948-0072
PHONE: (509) 865-3105

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

October 27, 1987

US Department of Health and Human Services
Health Care Financing Administration
Washington D.C. 20201

ATTENTION: William L. Roper, M.D., Administrator

MEDICARE PROVIDER NUMBER: 500037

The following information for Providence Central Memorial Hospital is to be attached to the Hospital Specific Report for the period December 1, 1985 through January 31, 1987, prior to public disclosure.

Providence Central Memorial Hospital is a 63-bed acute care facility, whose case mix includes many Medicare, Medicaid and medically indigent patients, with only 18% coming from the private sector. Many of our patients have major medical and surgical illnesses.

During a review of all of our patient deaths, our medical staff assesses standard of practice and standard of care in each case. Following an October, 1985 review by the Joint Commission of Accreditation of Hospitals, our facility, including quality assesssment, received a full 3-year accreditation.

The Hospital Specific Mortality Data reported by HCFA has been carefully reviewed by: the Hospital Administrator, Director of Patient Care Services, Director of Financial Services, President of the Medical Staff, Physician Chairman of the Utilization Review Committee, Director of Utilization Review, Quality Assessment, Director of Medical Records, and Coordinator for Community Relations.

In Category 15, the predicted mortality range was 9-85%. Our mortality was 100% (4 cases), as explained in the following:

1. All of these patients had multiple and irreversible end-stage diseases. 75% (3 out of 4) of patients in this category were long-term extended care residents.

SISTERS OF PROVIDENCE INSTITUTIONS—ALASKA: PROVIDENCE HOSPITAL, ANCHORAGE—OUR LADY OF COMPASSION CARE CENTER, ANCHORAGE—WASHINGTON: PROVIDENCE CENTRAL MEMORIAL HOSPITAL, TOPPENISH—PROVIDENCE HOSPITAL, EVERETT—PROVIDENCE MEDICAL CENTER, SEATTLE—THE DePAUL RETIREMENT RESIDENCE AND MOUNT ST. VINCENT NURSING CENTER, SEATTLE—ST. ELIZABETH MEDICAL CENTER, YAKIMA—ST. PETER HOSPITAL, OLYMPIA—ST. JOSEPH HOSPITAL, ABERDEEN—ST. HELEN HOSPITAL, CHEHALIS—OREGON: PROVIDENCE CHILD CENTER, PORTLAND—PROVIDENCE MEDICAL CENTER, PORTLAND—ST. VINCENT HOSPITAL AND MEDICAL CENTER, PORTLAND—SEASIDE GENERAL HOSPITAL, SEASIDE—PROVIDENCE HOSPITAL, MEDFORD—CALIFORNIA: PROVIDENCE HOSPITAL, OAKLAND—PROVIDENCE HIGH SCHOOL, BURBANK—SAINT JOSEPH MEDICAL CENTER, BURBANK.

2. Average age of these patients was 88.

3. 100% of these patients and/or their families had requested no resuscitation or artificial life support.

4. 100% mortality for this group was not unanticipated, but almost expected, contrary to the model. Our medical staff reviewed all deaths in our facility and felt optimum care had been given.

Thank you very much for allowing us to present this response.

Roy W. Holmes
Administrator

Douglas W. Shearer, M.D.
Acting Chief of Staff

PROVIDENCE HOSPITAL
PACIFIC & NASSAU
P.O. BOX 1067
EVERETT, WASHINGTON 98206-1067
PHONE: (206) 258-7123

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

October 23, 1987

William L. Roper, M.D.,
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, DC 20201

Dear Dr. Roper:

Thank you for the opportunity to comment on the release of mortality data for Medicare patients treated at Providence Hospital in 1986.

Providence Hospital is an acute care hospital which offers a wide range of services to our patients. We provide services in several specialty areas, including cancer care and treatment, orthopedics, and rehabilitative medicine, in addition to the more traditional general medical, surgical, and major and minor emergency services. The primary mission of Providence Hospital is to provide high quality care to our patients by maintaining levels of excellence in our care-giving staff respecting the worth and dignity fo the individual.

As part of this continuing commitment to quality of care, the hospital's medical staff conducts a comprehensive review of the medical record of every patient who expires in this facility. This review examines aspects of medical management and the overall quality of care which was provided to the patient. Mortality review, as this activity is termed, is an ongoing, integral part of our Quality Assessment and Peer Review Program.

The hospital specific mortality data reported by HCFA has been carefully reviewed by administration, physician chairpersons of the Quality Assessment and Utilization Management Committees and members of the hospital's management staff. We have validated, to the degree possible, that the data included in this report is accurate. Overall, our mortality rate falls within the predicted range for hospitals determined to be our peers and, we specifically note that our rates fall at the lower end of the predicted ranges in five high-risk categories.

SISTERS OF PROVIDENCE INSTITUTIONS—ALASKA: PROVIDENCE HOSPITAL, ANCHORAGE—OUR LADY OF COMPASSION CARE CENTER, ANCHORAGE—**WASHINGTON:** PROVIDENCE CENTRAL MEMORIAL HOSPITAL, TOPPENISH—PROVIDENCE HOSPITAL, EVERETT—PROVIDENCE MEDICAL CENTER, SEATTLE—THE DePAUL RETIREMENT RESIDENCE AND MOUNT ST. VINCENT NURSING CENTER, SEATTLE—ST. ELIZABETH MEDICAL CENTER, YAKIMA—ST. PETER HOSPITAL, OLYMPIA—ST. JOSEPH HOSPITAL, ABERDEEN—ST. HELEN HOSPITAL, CHEHALIS—**OREGON:** PROVIDENCE CHILD CENTER, PORTLAND—PROVIDENCE MEDICAL CENTER, PORTLAND—ST. VINCENT HOSPITAL AND MEDICAL CENTER, PORTLAND—SEASIDE GENERAL HOSPITAL, SEASIDE—PROVIDENCE HOSPITAL, MEDFORD—PROVIDENCE MILWAUKIE HOSPITAL, MILWAUKIE—**CALIFORNIA:** PROVIDENCE HOSPITAL, OAKLAND—PROVIDENCE HIGH SCHOOL, BURBANK—SAINT JOSEPH MEDICAL CENTER, BURBANK.

It is our intention to continue to evaluate the quality and appropriateness of care provided to all patients who seek our services. Thank you again for the opportunity to present this response.

Sincerely,

PROVIDENCE HOSPITAL

Carl A. Munding
Administrator
cc: Sisters of Providence Quality of Care Committee

L.082.JL

Health Services Committee, Providence Community Board
Washington State Hospital Association

PROVIDENCE MEDICAL CENTER
500 17th AVENUE
P.O. BOX C-34008
SEATTLE WASHINGTON 98124
PHONE (206) 320-3555

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

October 23, 1987

Mr. Harvey Brook
Health Care Financing Administration
Department of Health and Human Services
Attention: HS-148-GNC
P. O. Box 26676
Baltimore, Maryland 21201

Dear Mr. Brook:

Thank you for the opportunity to comment on this hospital's 1986 Medicare patient mortality data prior to publication in December, 1987. Since receiving your letter of September 21, 1987, our Medical Record Department and Quality Assurance staffs have reviewed the data in detail.

Review of the data found one to two percent variances in HCFA mortality rate calculations for the diagnostic categories of Cancer, Cerebrovascular Accident, and Pulmonary Disease. We calculate the Sepsis mortality rate to be 33 percent, rather than the 44 percent shown in your initial report.

At Providence Medical Center all patient charts are reviewed to insure that high quality care has been given. Our review, as well as the HCFA mortality data confirms the outstanding reputation of Providence Medical Center for providing excellent medical care.

Sincerely,

Peter Bigelow
Administrator

William M. McKee, M.D
Medical Director

PB:WMMcK:kc

SISTERS OF PROVIDENCE INSTITUTIONS—ALASKA: PROVIDENCE HOSPITAL, ANCHORAGE—OUR LADY OF COMPASSION CARE CENTER, ANCHORAGE—**WASHINGTON:** PROVIDENCE CENTRAL MEMORIAL HOSPITAL, TOPPENISH—PROVIDENCE HOSPITAL, EVERETT—PROVIDENCE MEDICAL CENTER, SEATTLE—THE DePAUL RETIREMENT RESIDENCE AND MOUNT ST. VINCENT NURSING CENTER, SEATTLE—ST. ELIZABETH MEDICAL CENTER, YAKIMA—ST. PETER HOSPITAL, OLYMPIA—ST. JOSEPH HOSPITAL, ABERDEEN—ST. HELEN HOSPITAL, CHEHALIS—**OREGON:** PROVIDENCE CHILD CENTER, PORTLAND—PROVIDENCE MEDICAL CENTER, PORTLAND—ST. VINCENT HOSPITAL AND MEDICAL CENTER, PORTLAND—SEASIDE GENERAL HOSPITAL, SEASIDE—PROVIDENCE HOSPITAL, MEDFORD—PROVIDENCE MILWAUKIE HOSPITAL, MILWAUKIE—**CALIFORNIA:** PROVIDENCE HOSPITAL, OAKLAND—PROVIDENCE HIGH SCHOOL, BURBANK—SAINT JOSEPH MEDICAL CENTER, BURBANK.

PUGET SOUND HOSPITAL

Moving Ahead

Provider Nos.:
500045
50S045
50V045

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for this opportunity to respond and comment upon the 1986 mortality statistics for the 16 diagnostic categories compiled and released by HCFA in 1987. The data has been reviewed by our Quality Assurance and DRG Committees, and was found to be accurate and comprehensive.

As a general acute care medical facility, Puget Sound Hospital provides medical and surgical services to patients with a broad spectrum of illnesses, injuries and conditions. Our patients represent all ages, socio-economic groups and severity of illnesses. Providing the best medical care possible in all circumstances is our uncompromising goal, and we are very pleased to note that our mortality statistics during the surveyed period were within or below the HCFA predicted ranges in 15 of the 16 categories. In four categories we experienced no mortalities whatsoever, and in seven others our actual mortality rate fell at the lowest end of the predicted range.

The single instance where our actual mortality rate exceeded the HCFA predicted rate was in severe acute heart disease. In this instance the HCFA prediction calculated a range of 21% - 56% mortalities, while our actual rate was 60% - four percentage points higher than the range. All deaths which occur in our facility are reviewed by the Quality Assurance Committee and Medical Staff Committees to confirm the appropriateness of care rendered. In the review of the mortalities cited in this category we have found no deficiencies in the quality of care provided, nor any deviations from accepted standards of care. In addition, the following should be noted:

215 So. 36th St. P.O. Box 11412 Tacoma, WA 98411-0412 (206) 474-0561

An American Healthcare Management, Inc. Facility

- The statistics cited represent 18 deaths out of 30 admissions in 1986;
- 8 of those patients (44%) were age 80 or greater;
- 14 of those patients were brought to the hospital by ambulance, in serious or critical condition at the time of their transport to the hospital;
- 11 of those patients were admitted with unstable vital signs, and 8 experienced additional complications such as shock, coma and ventricular fibrillation (rapid erratic heartbeat) at home prior to admission;
- 7 of the patients were, by personal and family request and with the concurrence of their physician, "no code" patients; that is, no mechanical life support systems were to be used in their care;
- 6 of the patients arriving by ambulance received advanced cardiac life support treatment prior to transfer to the hospital.

Puget Sound Hospital welcomes studies of this kind which reaffirms the success of our quality assurance efforts, and helps us focus our attention on those areas where we continually strive to improve.

Sincerely,

Bruce Brandler
Administrator

Dennis C. Koukol, M.D.
Chief of Staff

QUINCY VALLEY HOSPITAL

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, Maryland 21207

Thank you for this opportunity to respond to the release of hospital Medicare mortality information for the December 1985 to December 1986 inpatient admissions for Quincy Valley Hospital from the Health Care Financing Administration (HCFA).

Our hospital is a small, rural facility serving the health care needs of a large surrounding community. Our hospital services also include a Medicare-certified Swing Bed program. Some of the individuals treated here are stabilized in life-threatening situations and transferred to a larger facility thirty-five miles away. These same individuals often return to Quincy Valley Hospital to be close to family and to receive care at the end stage of their terminal illnesses.

The Medical Staff at Quincy Valley Hospital reviews the medical record of every patient who expires at this facility regarding the appropriateness and quality of care given to that individual. We utilize experts from across the state to assist the hospital in a constant endeavor to identify opportunites to improve our quality of care.

The hospital-specific mortality data reported by HCFA has been reviewed by our: Hospital Administrator; Chief of Staff; Director of Nursing and Director of our Medical Records Department. With minor exceptions we find the data to be accurate. Although the statistics for our hospital are based on small numbers due to our size, we note our actual mortality data falls well within the range of predicted rates for similar hospitals with our same characteristics, patient mix and case-mix. We were concerned that one of the deaths listed occurred within a HCFA identified "Low Risk" category. On re-review of this chart, the hospital discovered the patient had terminal, end-stage cancer and the disease was a complication of the cancer. Please be assured we have again reviewed each patient case-record involved for quality of care.

We feel there is a need in the nation's health care system for a small, rural community, non-profit hospital dedicated to individualized, quality care.

Sincerely yours,

Kim Dahlman, Administrator

R. G. McKinney, M.D., Chief of Staff

KD/RGM:jn

908 TENTH AVENUE SOUTHWEST QUINCY, WASHINGTON 98848 TELEPHONE (509) 787-3531

SHMC
SACRED HEART MEDICAL CENTER
West 101 Eighth Avenue
TAF-C9
Spokane, Washington 99220-4045
509 455-3041

OFFICE OF THE PRESIDENT

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: Mortality Statistics

To whom it may concern:

Thank you for the opportunity to respond to the release of hospital mortality rates.

We have carefully reviewed the rates for Sacred Heart Medical Center and the interpretative material that accompanied them. In no diagnostic category did the Medical Center's actual mortality rate fall outside the range of the predicted rate. The Director of Medical Records has validated that, overall, the data is accurate.

There is one aspect of the report that we believe should be clearly discussed in the release of the data to the public:

The range of predicted mortality rates was specifically developed for each hospital on the basis of such variables as its range of services and types of patients. This makes direct comparisons between hospitals within a community, region or the nation impossible.

Sacred Heart is a 615 bed hospital that treats patients with major and critical medical and surgical illnesses. It is a full service hospital with a wide range of specialities including heart surgery, kidney dialysis and transplant, cancer treatment, a hospice program, and a comprehensive rehabilitation service including care of head and spinal cord injuries. It is our understanding that the range of patients receiving treatment at Sacred Heart was taken into consideration when the Medical Center was assigned a mortality range.

A CENTURY OF CARING
Sisters Of Providence
1856 1956

Mortality review is a part of the ongoing Quality Assurance Program and continual monitoring of the medical management and care of Sacred Heart patients. The medical staff conducts a comprehensive review of the medical records of all patients who expire at the Medical Center. The HCFA mortality data will become an additional resource in this review. It is our belief that monitoring of quality care is critically important by individual hospitals as an assurance to the public that their confidence is well placed.

Sincerely,

Sister Peter Claver,
President

SP2

Skagit Valley
Hospital
and Health
Center

October 23, 1987

William L. Roper, M. D.
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

We appreciate the opportunity to review and respond to the mortality data being published by the Health Care Financing Administration. In all 16 categories reported, Medicare data for Skagit Valley Hospital and Health Center were within the predicted ranges. Comparison of Medicare data with records in our facility verify that all patients in the data listing were treated here. Of these 122 patients who expired from January 1, 1986 - January 31, 1987, 95 (78%) were greater than 70 years of age. (The time period for the data is longer than the calendar year because the statistical model HCFA used includes patients who expired within 30 days after admission.) Only 62% of the 122 patients actually expired in the hospital.

As a community with desirable characteristics for retirement, we serve a growing Medicare population. Skagit Valley Hospital and Health Center is a designated Rural Referral Center for Medicare patients and offers a wide variety of services to the public including oncology, cardiovascular, critical care, emergency, sophisticated diagnostic equipment, among others.

Sincerely,

Patrick R. Mahoney
Administrator

cle

1415 East Kincaid
P.O. Box 1376
Mount Vernon, WA
98273-1376
(206) 424-4111

ST. ELIZABETH MEDICAL CENTER
110 SOUTH NINTH AVENUE
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PHONE (509) 575-5000

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

October 23, 1987

RE: HCFA Mortality Statistics for 1986
St. Elizabeth Medical Center
Yakima, Washington
Medicare Provider #50-0012

St. Elizabeth Medical Center, Yakima, WA., requests that the following information be included in the Federal Register.

St. Elizabeth Medical Center, a referral center with 214 licensed beds, is the sole provider of a number of specialty services for a 4600 square mile area of Washington State. Those services include kidney dialysis, sleep lab, lithotripsy, physical rehabilitation and a comprehensive heart program, including open heart surgery and cardiac diagnostic and treatment services. We serve a high number (56%) of Medicare patients. Our case mix reflects a high percentage of patients with major medical and surgical illnesses; as a result, the "seriousness" of illnesses treated at St. Elizabeth is 50% higher than at any other Central Washington hospital.

St. Elizabeth Medical Center falls within the range of predicted mortality rate in all 16 diagnostic categories. The hospital-specific mortality data has been carefully reviewed by: the Administrator and Assistant Administrators, the President and other officers of the Medical Staff, the Medical Director of Quality Management and the Director and staff of the Utilization/Quality Management Department.

Through our Quality Management Program, the clinical practice of physicians, nurses and other health care personnel is carefully monitored on an on-going basis to assure that quality care is given to all patients. As part of that process, every death is monitored, by St. Elizabeth's medical staff committees and by the hospital's Quality Management staff. We

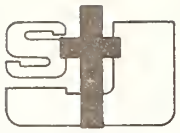
believe that our monitoring system provides us with a continuous feedback mechanism in an effort to continue to meet and exceed quality care standards. This commitment to quality care has been recognized by the Joint Commission on Accreditation of Hospitals in their accreditation surveys.

Thank you for the opportunity to comment in the Federal Register.

Sincerely,

Sister Karin Dufault, R.N., Ph.D.
Administrator

Kessler Campus
1614 E. Kessler Blvd.
Longview, WA 98632



ST. JOHN'S MEDICAL CENTER

Broadway Campus
600 Broadway
Longview, WA 98632

October 22, 1987

William L. Roper, M.D.
Administrator, HHS
Health Care Financing Administration
Washington D.C. 20201

RE: Inclusion of comments with Mortality Information for publication in December in the Federal Register

Dear Dr. Roper:

St. John's Medical Center is a Rural Referral Center in Southwest Washington serving patients in a five county area. The case mix, in addition to the general medical/surgical patient includes oncology services, dialysis and neurosurgical patients. The medical staff participates in an ongoing Quality Assurance Program that among other things, reviews all deaths that occur in the hospital on a case by case basis. The hospital's deaths that occurred in HCFA's Medicare mortality listings have already been reviewed by hospital specialty peer review committees.

The mortality information reflecting hospitalized Medicare patients, who died within 30 days of their last 1986 admission at St. John's Medical Center, showed all categories to be within the "predicted range of percentages of those who would be expected to die given adjustments for patient mix". It does not, however, reflect how severe the illness was at the time of admission or the severity of existing chronic conditions. The assigned diagnostic category for the patient is chosen by the "reason for admission", e.g. pneumonia, intestinal obstruction, and would not reflect the severity of a patient's secondary condition such as cancer metastases or terminal stages of cancer. This causes distortion of the "Range of Predicted Mortality Rates". In many instances the likelihood that death would have occurred in a short time is related to the terminal nature of the patient's illness and not necessarily related to the hospitalization. The same is true for patients with advanced heart conditions that appear in the "low risk" gastrointestinal disease category. They may do well through a surgical recovery, are discharged and yet die of an unrelated massive heart attack near the end of the 30 day period included in the mortality listing. This is reflected in the sampling checked in reviewing the mortality statistics. These are some of the factors not built in to the mortality statistics model.

A sampling of HCFA Mortality Information for accuracy, showed a 3% error rate for both primary reason for admission and for reported death at our facility. There were other minor variations in listing of sex or age which could be attributed to key punch error.

The HCFA Mortality Statistics for 1986 are under review by the formalized Quality Assurance organization within St. John's Medical Center. This review responsibility has been in place many years, and will continue to address quality of care monitoring in the hospital setting.

We agree with HCFA, that the mortality rate on its own "is not a complete measure of the quality of care at an individual hospital" The statistics do however, provide an opportunity to focus a case by case investigation on categories that show excessively high or low variations from the predicted range to see if a problem exists. These and similar issues are addressed on an ongoing basis by hospital committees as part of the Medical Center's Quality Assurance Program.

I appreciate the opportunity to respond to the releases of this information and would hope that additional questions would be directed to this Medical Center's Community Relations Department.

Sincerely,

Sister Anne Hayes,
Administrator
St. John's Medical Center
Medicare Provider #500041

Southwest
Washington
Hospitals

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Doctor Roper:

We are pleased with the results and appreciate the opportunity of reviewing the HCFA Mortality Statistics. We understand and endorse the recommendation in your September 21, 1987, letter that this information should not be used to make judgments about quality of care at specific hospitals or for comparisons among hospitals.

The statistics for St. Joseph Community and Vancouver Memorial Hospitals were carefully reviewed by the hospital administrator, members of the medical staff, and representatives from Quality Assurance and Medical Records. Our overall percentage of deaths is in the low to median area of the predicted ranges, with the exception of one category at Vancouver Memorial Hospital.

The expected rate for sepsis at Vancouver Memorial Hospital was 8% to 96%. Both patients died, resulting in a 100% mortality.

* Patient #1 was 80 years old with chronic leukemia who became septic along with other serious medical problems The patient and family chose to have care provided for comfort only.
* Patient #2 was 69 years old in chronic kidney failure who also had cardiac problems and developed an acute abdominal problem requiring surgery. The patient refused surgery and requested treatment for comfort only.

In both cases, the sepsis was a result of the final failure of the body to fight the pre-existing disease process.

Our medical staff reviews each death that occurs in our facilities on an ongoing basis and will continue to do so. We believe that our system provides continuous feedback which achieves our goal of meeting and exceeding quality standards.

Southwest Washington Hospitals has strong cancer, hospice and home health programs. The hospital works closely with nursing home facilities which are able to take patients who no longer need the hospital level of care. The majority of deaths that occur after discharge are under the auspices of these programs.

We appreciate the opportunity of reviewing the data and look forward to continued excellence of services provided at Southwest Washington Hospitals.

Sincerely yours,

Jeffrey D. Selberg
President

Thomas S. Dietrich, M.D.
President, Medical Staff

lc

ST. JOSEPH HOSPITAL
1006 NORTH "H" STREET
ABERDEEN, WASHINGTON 98520
PHONE (206) 533-0450

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

October 23, 1987

William L. Roper, M.D.
Healthcare Financing Administration
Department of Human Services
6325 Security Blvd.
Baltimore, MD 21207

Dear Dr. Roper:

The following information for St. Joseph Hospital, Aberdeen, is to be attached to the hospital specific report for the period October 1, 1984 through September 30, 1986, prior to public disclosure.

St. Joseph Hospital is an acute and long-term care facility whose case mix includes many patients with major medical and surgical illnesses. We are a full service hospital offering care in many specialty areas, as well as general medicine and surgery.

The medical staff at St. Joseph Hospital conducts an intensive review of the medical records of every patient who expires at this facility regarding medical management and overall care. Mortality review is an ongoing process of the quality assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at this hospital.

The hospital specific mortality data reported by HCFA, has been carefully reviewed by the hospital administrators, president of the medical staff, physician chairman of the utilization review committee, the director of utilization review and quality assurance, as well as the director of medical records. Our overall percentage of death is less than the statewide average, which reaffirms the quality of care provided to the patients of Grays Harbor County by St. Joseph Hospital and it's medical staff.

This hospital is confident that this data accurately reflects the mortality rate at St. Joseph Hospital. As previously stated, review by this facility is always by individual case, regarding overall quality of care and is conducted in an ongoing fashion, not just when statistics such as mortality data are requested.

Thank you for allowing us the opportunity for this review.

Sincerely,

Sr C. Van Dyke SP

Sister Charlotte Van Dyke, S.P.
Administrator

SISTERS OF PROVIDENCE INSTITUTIONS—ALASKA: PROVIDENCE HOSPITAL, ANCHORAGE—OUR LADY OF COMPASSION CARE CENTER, ANCHORAGE—WASHINGTON: PROVIDENCE CENTRAL MEMORIAL HOSPITAL, TOPPENISH—PROVIDENCE HOSPITAL, EVERETT—PROVIDENCE MEDICAL CENTER, SEATTLE—THE DePAUL RETIREMENT RESIDENCE AND MOUNT ST. VINCENT NURSING CENTER, SEATTLE—ST. ELIZABETH MEDICAL CENTER, YAKIMA—ST. PETER HOSPITAL, OLYMPIA—ST. JOSEPH HOSPITAL, ABERDEEN—ST. HELEN HOSPITAL, CHEHALIS—OREGON: PROVIDENCE CHILD CENTER, PORTLAND—PROVIDENCE MEDICAL CENTER, PORTLAND—ST. VINCENT HOSPITAL AND MEDICAL CENTER, PORTLAND—SEASIDE GENERAL HOSPITAL, SEASIDE—PROVIDENCE HOSPITAL, MEDFORD—PROVIDENCE MILWAUKIE HOSPITAL, MILWAUKIE—CALIFORNIA: PROVIDENCE HOSPITAL, OAKLAND—PROVIDENCE HIGH SCHOOL, BURBANK—SAINT JOSEPH MEDICAL CENTER, BURBANK.

ST. JOSEPH HOSPITAL AND HEALTH CARE CENTER

Oct. 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Thank you for providing us with this opportunity to respond to the information compiled by the Health Care Financing Administration regarding hospital mortality rates during the period between January 1986 and January 1987

A review of the material indicates that the information is correct for the most part. Minor discrepancies were found and are noted for your information in the enclosed documents, but they do not significantly affect the reported mortality rates.

We have noted that St. Joseph Hospital fell within or below the predicted ranges in all categories. The actual mortality rate for cancer patients was 2 percent less than what was predicted.

We realize these data are not controlled sufficiently to measure the quality of care provided by our hospital or other institutions. Therefore, it is not possible to draw specific conclusions about performance from these statistics.

As part of the quality assurance program at St. Joseph Hospital the medical staff routinely reviews the records of each patient who dies and monitors the appropriateness of the total care provided.

1718 SOUTH I STREET, P.O. BOX 2197, TACOMA, WASHINGTON 98401 (206) 627-4101

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

It is important to look at these statistics in light of the intensive services offered at St. Joseph Hospital. St. Joseph Hospital is a referral center with services that attract critically ill patients from throughout the region. These services include the region's only inpatient and outpatient renal dialysis units, the only burn center in the area and a comprehensive emergency department.

Again, thank you for this opportunity to respond to the mortality statistics.

Sincerely,

John Long
President and Chief Executive Officer

St. Luke's
General Hospital
809 East Chestnut Street
Bellingham, Washington 98225
(206) 734-8300

October 23, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for the opportunity to respond to the release of data on hospital specific mortality rates for 1987. The data has been carefully reviewed and its accuracy validated by our Director of Medical Records and Quality Assurance Coordinator.

Based on the comprehensive review of the data and the specific medical records it reflects, we are confident that any member of the public who requests a copy of our statistical information would be pleased to see the figures represented. St. Luke's General Hospital consistently remains within the expected mortality ranges for our type of facility.

We believe quality of care is an important issue which deserves scrutiny on an on-going basis, not just when statistics such as the mortality data are released. Therefore, St. Luke's Hospital Medical Staff conducts an intensive review of the medical record of every patient who expires at our facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the healthcare delivery system at St. Luke's General Hospital.

We appreciate your efforts in assembling this data.

Sincerely,

William G. Gordon
Executive Vice President/
Chief Executive Officer
St. Luke's General Hospital

Robert Harris, M.D.
Chief-of-Staff
St. Luke's General Hospital

/kk

ST. LUKE'S MEMORIAL HOSPITAL

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Post Office Box 2868
Spokane WA
99210-0288

(509) 838-4771

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Colleagues in Health Care:

In review of the 1986 HCFA mortality data, St. Luke's Memorial Hospital offers the following response. The Medicare provider number for St. Luke's Memorial Hospital is 500035.

Located in Spokane, Washington, St. Luke's Memorial Hospital is a 146 bed non-profit hospital. It is recognized for its strong rehabilitation, neurosurgery and orthopedic services whereby referrals are received from physicians and other hospitals in Western Montana, Northern Idaho and Eastern Washington. The rehabilitation unit treats primarily brain injury and stroke patients.

The Medical Records and Utilization Management departments have reviewed and confirmed that, with minor exceptions, the HCFA data is correct. The data has also been reviewed in conjunction with appropriate Medical Staff and Quality Assurance Committees.

St. Luke's Memorial Hospital's Medical Staff reviews and will continue to review all mortality cases to assure that the care is appropriate and consistent with the severity of the illness. Information obtained as a result of these reviews is used in efforts to maintain a high standard of care.

The appropriate assessment of hospital performance is dependent upon many variables and requires a study of many quality indicators of which mortality is but one. In order to more clearly understand the accompanying data, the following information is provided.

Two diagnostic categories, low risk heart disease and severe acute heart disease, are detailed.

Diagnostic Category-Low Risk Heart Disease

--The average age for these patients was 83 years old.
--Two patients had multiple diseases for which death was imminent. (One of these two died in the hospital, the other requested to be sent home.)
--One patient had multiple chronic conditions involving congestive heart disease. (Nursing home placement was recommended but refused.)

Diagnostic Category-Severe Acute Heart Disease

--The average age for these patients was 78 years old.
--The five individuals were fragile elderly with multiple chronic conditions which included arterial sclerotic disease, chronic obstructive pulmonary disease, diabetes and congestive heart failure.

If we can be of assistance to you or anyone else receiving this information, please do not hesitate to call.

With Best Regards,

Thomas M. White
President

Medicare Provider #50-0024

ST. PETER HOSPITAL
413 NORTH LILLY ROAD
OLYMPIA, WASHINGTON 98506
PHONE: (206) 491-9480

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To whom it may concern:

Please attach the following information from St. Peter Hospital to the HCFA Medicare patient mortality report for 1986:

St. Peter Hospital is a 340-bed regional referral center serving five counties. Our case mix includes many patients with serious medical and surgical illnesses. We are a full service medical center offering care in the specialty areas of oncology, pediatrics, coronary care, orthopedics, neurology, obstetrics, intensive care, kidney dialysis, ophthalmology, psychiatry, and chemical dependency, as well as general medicine and surgery.

On an ongoing basis, our medical staff physicians and quality assurance representatives review mortalities in our facility to assure that appropriate care and medical management has been given. Our Director of Medical Records has verified that, with minor exceptions, the HCFA data on St. Peter Hospital is accurate.

In overall predicted mortality for all causes of death, St. Peter Hospital fell below the midpoint of HCFA's predicted percentage. In fact, for 12 of the 16 diagnostic categories selected for analysis by HCFA, St. Peter Hospital was at or below the midpoint. Although still well within the predicted range, our hospital appears to be above the midpoint in four "high risk" areas--cerebrovascular accidents, severe chronic heart disease, metabolic/electrolyte disturbances, and pulmonary disease. We believe that our higher statistical mortality for Medicare patients in these categories is due to the severity of illness of the patients we treat. As a regional referral center, many severely-ill patients are transferred to us from nursing homes and smaller hospitals in a five-county area.

Today's consumers have a right to know how well hospitals perform. Due to differences in types of patients treated, geographic location, referral arrangements between hospitals and other factors, it is very difficult to come up with a "yardstick" for measuring quality of care. The HCFA data provides some useful information on one group of patients--Medicare recipients who have died. The American Hospital Association and the Joint Commission on Accreditation of Health Care Organizations are now investigating methods of

SISTERS OF PROVIDENCE INSTITUTIONS—ALASKA: PROVIDENCE HOSPITAL, ANCHORAGE—OUR LADY OF COMPASSION CARE CENTER, ANCHORAGE—WASHINGTON: PROVIDENCE CENTRAL MEMORIAL HOSPITAL, TOPPENISH—PROVIDENCE HOSPITAL, EVERETT—PROVIDENCE MEDICAL CENTER, SEATTLE—THE DePAUL RETIREMENT RESIDENCE AND MOUNT ST. VINCENT NURSING CENTER, SEATTLE—ST. ELIZABETH MEDICAL CENTER, YAKIMA—ST. PETER HOSPITAL, OLYMPIA—ST. JOSEPH HOSPITAL, ABERDEEN—ST. HELEN HOSPITAL, CHEHALIS—OREGON: PROVIDENCE CHILD CENTER, PORTLAND—PROVIDENCE MEDICAL CENTER, PORTLAND—ST. VINCENT HOSPITAL AND MEDICAL CENTER, PORTLAND—SEASIDE GENERAL HOSPITAL, SEASIDE—PROVIDENCE HOSPITAL, MEDFORD—PROVIDENCE MILWAUKIE HOSPITAL, MILWAUKIE—CALIFORNIA: PROVIDENCE HOSPITAL, OAKLAND—PROVIDENCE HIGH SCHOOL, BURBANK—SAINT JOSEPH MEDICAL CENTER, BURBANK.

evaluating hospital quality that rely on measures other than mortality rates.

St. Peter Hospital strives to provide the best possible care for all its patients. Review of cases for overall quality of care is conducted on an ongoing basis--not just when statistics such as the mortality data are released.

Thank you for giving us the opportunity to comment on this information.

Sincerely,

Gary Wangsmo
Assistant Administrator

SAINT
CABRINI
HOSPITAL
OF SEATTLE

Terry & Madison
Seattle, Washington 98104
(206) 682-0500

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper,

Thank you for this opportunity to respond to the release on hospital mortality rates for 1986.

Saint Cabrini Hospital is a 189-bed general and specialty hospital which has a primary focus on geriatrics, ophthalmology, ambulatory surgery, chemical dependency treatment, psychiatry, eating disorders treatment and select diagnostic and treatment programs. Our geriatrics program includes an acute medical-surgical unit, a skilled nursing facility, primary care clinics and outreach services.

Saint Cabrini Hospital, its Medical Staff and Governing Board, are committed to our comprehensive quality assurance program that endeavors to ensure quality care is provided to members of the community we serve as patients.

The hospital specific mortality data reported by HCFA has been reviewed and its accuracy verified by the hospital quality assurance coordinator, in conjunction with the Hospital Administrator, President of the Medical Staff, Chairman of the Quality Assurance Committee.

The Medical Staff of Saint Cabrini Hospital conducts an intensive review of the medical record of <u>every</u> patient who expires at this facility regarding medical management and overall care. Mortality review is an on-going process of the Quality Assurance program and peer review activities are an integral part of the monitoring of the health care delivery system at our hospital. Saint Cabrini Hospital is fully accredited by the Joint Commission on Accreditation of Hospitals (JCAH). This includes JCAH approval of our Quality Assurance Program and peer review process.

Thank you for the opportunity to present this response.

Sincerely,

Ronald C. M. Bergstrom

Ronald C. M. Bergstrom
Administrator

STEVENS
MEMORIAL
HOSPITAL
PUBLIC HOSPITAL DISTRICT NO. 2
SNOHOMISH COUNTY

JON D. SMILEY
Hospital Administrator
ARTHUR H. HOSICK
FRED J. MCFARLAND
ALBERT THURMOND
Hospital District Commissioners

October 26, 1987

William L. Roper, M.D.
HEALTH CARE FINANCING ADMINISTRATION
Health Stardards & Quality Bureau
Hospital Mortality Information
6325 Security Blvd.
Baltimore, MD 21207

MEDICARE PROVIDER NO.: 500026

Dear Dr. Roper and Staff:

We appreciate that the release of the Stevens Memorial Hospital mortality (death) rates for 1986 will be accompanied by the following comments, which we hope will help our community understand the data.

Stevens Memorial Hospital is a 217-bed acute care hospital. In acute care hospitals, only very ill patients or those needing major surgeries or procedures are cared for as inpatients (those who stay at least one night). Aside from medical and surgical patients, Stevens Memorial also cares for patients in its specialty care units: intensive, coronary and progressive care units, as well as through its nationally certified Cancer Care Program. Stevens' diagnostic imaging center allows its physicians to use the finest testing equipment available to help them determine the best treatment for the patients. Stevens Memorial Hospital also has exciting new laser equipment used in surgery by some of our eye surgeons, gynecologists and ear, nose and throat specialists. The laser allows for more accurate and safer surgeries. Stevens has a very busy maternity service and newborn nursery, and facilities for inpatient psychiatric treatment. Stevens Memorial has one of the busiest Emergency Departments in Washington. Medic 7 is based here, and many very ill patients are admitted to Stevens through the Emergency Department. In 1986, Stevens Memorial had a Rehabilitation Unit, which was designed to care for people who had strokes and other brain injuries.

The chart of mortality rates for Stevens Memorial, and all other hospitals in the country, was put together by the Health Care Financing Administration (HCFA). HCFA is the agency of the federal government in charge of Medicare. The mortality rates for 1986 reflect the approximate number of "Medicare patients" (those 65 years old and above) with certain illnesses who were admitted to our hospital and "predicted" to be seriously ill enough to be at high risk for dying and the percentage of "Medicare patients" who actually died. The chart of mortality rates shows that Stevens Memorial Hospital's rates are all within the "predicted" ranges in each of the specific illness categories.

As HCFA has explained, they have used a complicated method for "predicting" the the high and low number of patients, given in a part or percentage of the total patients hospitalized in 1986. This method was used for each hospital; we look

forward to continued improvements in the ability to use all necessary information about the individual patients in order to make these mortality rates more meaningful. As you can well understand, people who have heart attacks or strokes are not all equally sick. Some patients are obviously more severely ill due to the seriousness of the event or because of other diseases they may have. HCFA obtained the information for the mortality rates from bills sent by the hospitals to Medicare for payment. Information about the severity of the patients' illnesses is not contained on the bills.

The mortality information for Stevens Memorial has been reviewed by its physicians and hospital administration for accuracy. In the categories of cerebrovascular accidents (strokes) and severe acute heart disease, Stevens' own internal statistics show that the mortality rates in 1986 were 20% and 34% respectively, rather than 40% and 46%. HCFA has given a few reasons about why their percentages and the hospitals' percentages may be different. Several of Stevens' rates are close to what HCFA has shown, and several are very different from our own counts.

The most important thing to consider is the quality of care at a hospital. The Medical Staff at Stevens Memorial Hospital conducts an intensive review of the medical record of every patient who dies to determine if the medical management and care delivered was appropriate and high quality. Mortality review is an ongoing process of the Quality Assurance program and peer review (physicians reviewing other physicians' care) is an important part of the evaluation of health care at Stevens Memorial. Quality of care can only be determined by individual case review. Unfortunately, the mortality rates presented do not provide enough information to make any judgments about the quality of care.

A second factor which is important when looking at the mortality rates is the individual choices made by patients and/or their families. The Medical Staff encourages patient participation in making decisions about their health care. There continue to be times when Stevens' patients have made personal choices in limiting the medical therapies they desire, including those which would prolong life. A majority of Stevens Memorial's "Medicare patients" are over the age of 75, and many have strong opinions about their health care. These desires are respected in order to preserve the dignity of each individual.

The Medical Staff and other personnel at Stevens Memorial Hospital are committed to a high level of quality in caring for their patients. The chance to provide some explanatory comments to our community about the mortality rates released by HCFA is greatly appreciated.

Sincerely,

Jon D. Smiley
Administrator

R E Bray, M.D.

Ronald E. Bray, M.D.
Chief of Staff

cc: Washington State Hospital Association

SWEDISH HOSPITAL MEDICAL CENTER
747 Summit Avenue Seattle, WA 98104

October 23, 1987

TO: HCFA
Health Standards and Quality Bureau
Hospital Mortality Information

REGARDING: HCFA Hospital Specific Mortality Data

Swedish does not wish to comment in advance of data release

The hospital staff will be available to discuss the mortality

information with interested parties. Provider # 500027.

Sincerely,

Brian Goodell

Brian W. Goodell, M.D.
Associate Executive Director for Medical Affairs

BWG/bw

Multicare Medical Center
Tacoma General Hospital

Hospital #500129

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

Thank you for the opportunity to respond to the release of data on Medicare Mortality Rates for 1986. Since receiving the report dated September 21, 1987, Tacoma General Hospital staff have had an opportunity to review the information provided. MultiCare Medical Center is a Tacoma, Washington based, not for profit, health care system including the combined services of Tacoma General Hospital and Mary Bridge Children's Hospital and Health Center. Tacoma General Hospital is a 418 bed acute care hospital offering a full spectrum of inpatient services from primary through tertiary levels of care. As a regional referral center for Southwest Washington and the Olympic Peninsula, the hospital provides for services unique to the region in high risk obstetrics, open heart surgery, cancer, and neonatology. As an example of our regional base, over 50% of newborns treated in the Newborn Intensive Care Unit come from outside Pierce County. In addition, level III neurosurgery, orthopedics (with an active joint replacement program), geriatrics, and emergency medical services are available. As one indication of how sick patients are coming to the institution, the Emergency Department admits to the inpatient units 26% of cases seen within that department, consistent with the high volume of patients brought there by ambulance. Furthermore, Tacoma General has the highest ratio of monitored beds to total beds of any hospital in the State of Washington.

Within its quality assurance program, the medical staff at MultiCare Medical Center conducts an intensive review of medical records of every patient who expires at this facility for medical management and overall care. Along with other monitored events, mortality review is an ongoing process of the Quality Assurance Program and the peer review activities are an integral part of the monitoring of health care delivery system at Tacoma General Hospital. The Joint Commission on Accreditation of Health Care Organizations recently complimented (in addition to accredited) this facility for its hospital Quality Assurance program and its model peer review process.

315 South K Street P.O. Box 5299 Tacoma, Washington 98405-0986 (206) 594-1000

Tacoma General Hospital • Mary Bridge Children's Health Center • Doctors Pavilion

Hospital #500129
October 26, 1987
Health Care Financing Administration

The hospital specific mortality data reported by HCFA has been carefully reviewed by the Hospital Administrator, Medical Director, the Director of Medical Records, the Director of Quality Assurance and the Director of Utilization Management.

In attempting to verify accuracy of the data provided by you, two patients listed as dying within the hospital did not, in fact, die to our knowledge during the course of their hospital admission. Furthermore, two patients were not found as having a record of being a patient within this facility within 1986 or the first part of 1987. One patient was listed having a different date of death, other than that provided. Of the patients listed as dying outside of the hospital within 30 days of admission, all were listed as patients at Tacoma General during 1986 and the first part of 1987. These discrepancies concern us.

We are pleased to note that our actual mortality rate falls within the range of predicted mortality rates for all sixteen diagnostic categories, as well as the seventeenth category which includes Medicare deaths from all other causes.

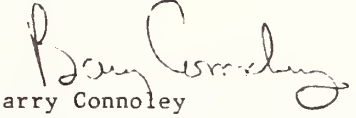
In summarizing our response, we feel it is imperative that individuals keep in mind the limitations of this summary data by diagnostic category which does not reflect the differences in diagnosis, procedures, severity of illness, patient population, age, complications, and reasons for death. Because standardization of data between institutions is not reflected given the differences listed, differences in data between hospitals should not be interpreted as a difference in quality of care.

As the only not for profit hospital in Tacoma solely owned and governed by a local community Board, we would like to close with a comment on the mission of this hospital. Tacoma General Hospital provides a high percentage of charity care consistent with our mission to provide care for all patients regardless of their ability to pay. In addition, over 17% of the care provided by the hospital is provided to welfare recipients.

The comprehensive nature of our quality assurance program will continue to review all deaths of individual patients within the hospital. Analysis of these reviews is a constant endeavor to assist and identify opportunities to improve care.

Thank you for the opportunity to present this response.

Sincerely,



Barry Connoley
President and Chief Executive Officer

BC:cas

TRI-STATE
memorial hospital, inc
1221 Highland Avenue • P. O. Box 189 • Clarkston, WA 99403 • (509) 758-5511

October 26, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

We appreciate the opportunity to respond to the release of hospital mortality data.

All cases listed in the HCFA mortality data release have been reviewed by our Quality Assurance Committee for appropriateness of care. It is the policy of Tri State Memorial Hospital to monitor all mortality cases on an ongoing basis, and we feel that our effort to meet and exceed quality care standards is reflected in our low percentage of actual mortality rate. Tri State Memorial Hospital's rates fall within the lower half of the range of predicted mortality rates in all diagnostic categories. In our ongoing endeavour to identify areas where care may be improved, Tri State Memorial Hospital will continue to monitor all mortality cases for appropriateness of quality of care.

Sincerely,

Dave Farlowe

Dave W. Farlowe
Administrator

University Hospital
University of Washington

October 23, 1986

Mr. Harvey Brook
6300 Security Blvd.
Meadows East Building
Room 2-D-2
Balitmore, Maryland 21207

RE: **Mortality Statistics about Medicare Patients Cared for During 1986**
Provider #: 50008

Dear Mr. Brook:

Thank you for the opportunity to include our comments with mortality data for the period December 1, 1985 through December 31, 1986.

The University Hospital at the University of Washington in Seattle is a major university affiliated referral center in the Pacific Northwest region. We serve patients from Washington, Idaho, Montana, Oregon and Alaska. We are particularly well known for our research and teaching efforts in the areas of heart disease, cancer treatment and perinatal care. As a result of these and other programs, many of the patients who come to University Hospital do so after treatment at other hospitals has been unsuccessful. Our casemix index, one measurement of severity of illness, serves to illustrate how gravely ill many of these patients are. In 1986 the casemix index at University Hospital was the highest among our peer teaching hospitals across the country at 1.7143. It was also the highest in the Western University Hospital Council which includes hospitals like University of California - Davis, University of California - Los Angeles and Stanford.

We have reviewed and validated the mortalities as identified by HCFA and, with a few minor differences, found the information about these patients to be accurate. All the identified mortalities were patients at University Hospital. Our mortality rates, as calculated by HCFA, fall within the expected ranges for all diagnosis categories. In only the category of Low Risk Heart Disease is our mortality rate at the high end of the expected range.

Predicted Range:	4 - 9 %
Computed Mortality Rate:	9 %

Hospital Administration

1959 NE Pacific Street, RC-34
Seattle, Washington 98195
(206) 548-6300

On analysis of Low Risk Heart Disease patients we found that all but 17 out of the identified 466 total patients had at least one other significant disease present in addition to the heart disease for which they were admitted. This again is an indication of the severely ill patients cared for by the University Hospital.

Attached is a table of data showing our mortality experience for Medicare patients in the sixteen categories. We attempted to match the HCFA data from our own internal database. We were unable to do so due to the following factors:

* HCFA's data takes into account only the last admission for these Medicare patients in 1986. We have no way of excluding from our data those patients who may have had their last admission at another hospital. Therefore, our total number of patients is higher than that identified by HCFA.

* HCFA's data includes patients who died within 30 days after admission to our hospital. It is unclear whether HCFA excluded from their calculation of the mortality rate patients whose length of stay exceeded 30 days.

We have displayed our data to take these conditions into consideration. However, the mortality rates calculated from our data fall within HCFA's expected ranges. It is also important to note that the overall mortality rate for all Medicare patients at University Hospital during calendar year 1986 was 8.5%.

In closing, we reiterate the commitment of University Hospital to the highest quality of care for all our patients. That commitment is demonstrated not only by the data presented, but also by our efforts in teaching the next generation of physicians and other medical care personnel.

Sincerely yours,

Irma Goertzen
Administrator,
University Hospital

Loren Winterscheid, M.D.
Medical Director, University Hospital
Associate Dean, School of Medicine

IG/LW/ks
Attachment

UNIVERSITY of WASHINGTON
University Hospital
Mortality Rates for Medicare Patients
1986

Column	All Pat. 1	Pat LFA* <31day 2	Pat LFA* >30day 3	Total Hosp. Mort. 4	Hosp. Mort. <31day 5	Out of Hosp. Mort. 6	Total Mort. 7	Actual Mort. (Pcnt) 8	HCFA Mort. (Pcnt) 9	HCFA Predict. Range 10
CA - Cancer	157	151	6	31	29	9	40	25.5%	24%	17-35%
CE - Cerebrovascular Accidents	18	17	1	8	8	1	9	50.0%	42%	13-53%
EY - Ophthalmologic Dis.	62	62	0	0	0	0	0	0.0%	0%	0-21%
GC - Gastrointestinal Catastrophes	21	19	2	6	4	1	7	33.3%	28%	7-46%
GI - Gastrointestinal Dis.	59	57	2	3	3	1	4	6.8%	8%	1-16%
GU - Urologic Dis.	39	38	1	2	1	0	2	5.1%	3%	1-22%
GY - Gynecologic Dis.	8	7	1	1	0	0	1	12.5%	0%	0-69%
HL - Low-risk Heart Dis.	466	453	13	43	37	2	45	9.7%	9%	4-9%
HM - Severe Chronic Heart Dis.	47	47	0	7	7	2	9	19.1%	14%	12-38%
HS - Severe Acute Heart Dis.	38	36	2	16	14	0	16	42.1%	38%	19-53%
ME - Metabolic/Electrolyte Disturb.	27	27	0	3	3	3	6	22.2%	25%	8-42%
OP - Orthopedic Disorders	134	131	3	0	0	0	0	0.0%	0%	0-6%
PN - Plumonary Dis.	60	60	0	14	14	0	14	23.3%	23%	9-30%
RN - Renal Dis.	29	21	8	3	2	2	5	17.2%	15%	3-44%
SE - Sepsis	4	4	0	2	2	0	2	50.0%	33%	9-75%
TR - Severe Trauma	14	14	0	1	1	0	1	7.1%	7%	1-38%
UN - Other Causes	1087	1023	64	26	21	7	33	3.0%	3%	NI **
ALL Causes	2270	2167	103	166	146	28	194	8.5%	10%	6-13%

* LFA Length of stay from admission.
** Not Identified

Valley Hospital and Medical Center

East 12606 Mission

Post Office Box 288
Spokane, WA
99210-0288

(509) 924-6650

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Colleagues in Health Care:

This letter is in response to the release of data on Valley Hospital and Medical Center's 1986 mortality rates. Our Medicare provider number is 500119.

Valley Hospital and Medical Center is a non-profit, 123 bed acute care facility whose services include major medical, surgical, critical care and family-centered maternity care.

Our Directors of Medical Records and Utilization Management have validated that, with minor exceptions, the HCFA data is accurate. The data has been screened against our internal data sources and found to be consistent. The Vice President of Quality Assurance has also reviewed the data in conjunction with appropriate Medical Staff members and Quality Assurance Committees.

The Medical Staff of Valley Hospital and Medical Center conducts an intensive review of the medical records of every patient who dies in our facility to assure that the care was appropriate and consistent with the severity of the illness.

In order to make the accompanying data more meaningful we profile the following information.

Diagnostic Category-Cerebrovascular Accidents

The range of predicted mortality rates in this category was 18 to 48 percent and ours was 40 percent. A profile of these patients is as follows:

--The average age for these 14 patients was 85 years old.
--Five of the patients had massive brain stem hemmorhage on admission and death was inevitable.
--Four of the patients were admitted comatose and unresponsive and did not respond to treatment.

Empire Health Services

--Five patients were discharged to nursing homes of which three patients were terminally ill on discharge. One patient died of pneumonia while another had lung cancer.

Diagnostic Category-Gastrointestinal Disease

The range of predicted mortality rates in this category was 2-10 percent and ours was 6 percent. A profile of these patients is as follows:

--The average age for these nine patients was 76 years old.

--Five were critically ill on admission with multiple disease conditions such as advanced heart disease, post stroke and malnutrition. One patient had Alzheimers disease and one had multiple sclerosis.

--One patient was admitted with advanced cirrhosis of the liver with liver failure and sepsis who developed respiratory failure. The patient was placed on mechanical ventilation and the family requested a "no code" status.

--One patient had a massive gastric hemmorhage and had gastric surgery. He suffered a heart attack.

--Two patients died after they left the hospital. One went to a nursing home with a terminal status. The other went home with cancer of the colon.

Diagnostic Category-Severe Trauma

The range of predicted mortality rates for this category was 3 percent to 23 percent and ours was 5 percent. A profile follows:

--This represents two cases (94 years old and 81 years old).

--Both patients were treated surgically for fractured hips suffered from falls in their places of residence. They were both suffering from pre-existing heart disease, congestive heart failure and expired from respiratory failure. They did not respond to treatment.

Understanding that a commitment to total patient care extends beyond hospitalization, Valley Hospital emphasizes discharge planning and coordination of post-hospital placement with patients and family. For example, patients and family may decide that a nursing home, hospice care or at-home care is the best alternative.

If more information is desired, please do not hesitate to call.

With Best Regards,

Thomas M. White
President

400 South 43rd Street
Renton, WA 98055
206•228•3450

Valley Medical Center

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington DC 20201

Dear Dr. Roper:

The statistics provided by H.C.F.A. for 1986 have provided a useful screening tool to augment methods used in our quality review process. The information has allowed Valley Medical Center to verify that our previously determined mortality rates for selected groups of patients are in reasonable agreement with H.C.F.A.'s data and national norms. We have found them useful also in confirming that no unrecognized pattern exists.

Valley Medical Center is a 303 bed acute care community referral and teaching facility. We have specialty areas of cardiology, oncology, orthopedic services, rehabilitative medicine, as well as general medicine and surgery.

The medical staff at Valley Medical Center participates in an intensive ongoing review process in a comprehensive quality assurance patient care monitoring program. This is a hospital-wide system incorporating practitioner peer review and involving records of all patients hospitalized at Valley Medical Center.

Quality can only be determined by adequate and in-depth peer review on a case by case basis, and by trend analysis. This is accomplished by our current programs which utilize data from a number of sources within the institution.

Although the accuracy of the Medicare data was not checked in all cases, a random sample was reviewed. The data seems reasonably accurate, although some discrepancies were noted. We do not feel, however, that defining these inaccuracies would significantly change the overall data nor affect its usefulness.

May we once again emphasize that while we recognize the value of mortality data in this form, we also are aware of the potential problems of misinterpretation given the limited predictive value of the information available. We found, for instance, that many of the patients who died within a month of leaving our institution were, in fact, terminally ill and expired as a result of their progressive illness and not of the illness attributed to their last hospitalization. Moreover, we believe that mortality figures do not necessarily indicate good or bad quality care. Such determinations can only be

made following in-depth case review. Our monitoring system appropriately provides such a mechanism.

Thank you for providing an opportunity to present this response.

Sincerely,

Richard D. Roodman
Administrator

RDR/mt

Southwest Washington Hospitals

October 27, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Doctor Roper:

We are pleased with the results and appreciate the opportunity of reviewing the HCFA Mortality Statistics. We understand and endorse the recommendation in your September 21, 1987, letter that this information should not be used to make judgments about quality of care at specific hospitals or for comparisons among hospitals.

The statistics for St. Joseph Community and Vancouver Memorial Hospitals were carefully reviewed by the hospital administrator, members of the medical staff, and representatives from Quality Assurance and Medical Records. Our overall percentage of deaths is in the low to median area of the predicted ranges, with the exception of one category at Vancouver Memorial Hospital.

The expected rate for sepsis at Vancouver Memorial Hospital was 8% to 96%. Both patients died, resulting in a 100% mortality.

* Patient #1 was 80 years old with chronic leukemia who became septic along with other serious medical problems The patient and family chose to have care provided for comfort only.
* Patient #2 was 69 years old in chronic kidney failure who also had cardiac problems and developed an acute abdominal problem requiring surgery. The patient refused surgery and requested treatment for comfort only.

In both cases, the sepsis was a result of the final failure of the body to fight the pre-existing disease process.

Our medical staff reviews each death that occurs in our facilities on an ongoing basis and will continue to do so. We believe that our system provides continuous feedback which achieves our goal of meeting and exceeding quality standards.

Southwest Washington Hospitals has strong cancer, hospice and home health programs. The hospital works closely with nursing home facilities which are able to take patients who no longer need the hospital level of care. The majority of deaths that occur after discharge are under the auspices of these programs.

We appreciate the opportunity of reviewing the data and look forward to continued excellence of services provided at Southwest Washington Hospitals.

Sincerely yours,

Jeffrey D. Selberg
President

Thomas S. Dietrich, M.D.
President, Medical Staff

lc

VIRGINIA MASON

Hospital

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

Thank you for the opportunity to comment on the Health Care Financing Administration's (HCFA) Medicare mortality data for Virginia Mason Hospital, Medicare provider number 50-0005.

Virginia Mason Hospital, established in 1920, is a 336-bed tertiary care facility. A majority of our patients have major medical illnesses and require very specialized treatment. Many of our patients come from other states including Alaska, Montana, Idaho, and Utah, so we are considered a regional referral center. As a full service medical facility, Virginia Mason offers comprehensive care in the areas of heart, cancer, diabetes, and urology, to name just a few.

Virginia Mason is committed to offering its patients the highest quality health care possible. Part of that commitment includes carefully reviewing the medical records of <u>every</u> patient who receives care at our hospital. We continually monitor our patient care delivery systems to make sure our medical staff, as well as our methods of care and treatment, meet the strict criteria developed by our Quality Assurance Program. We immediately investigate any indication of potential quality problems and take prompt action to improve our hospital's performance.

Physicians, administrators and other Virginia Mason Hospital personnel carefully reviewed the statistics HCFA used for this report. HCFA reported on 3,069 Virginia Mason patients. This number represents 86 percent of all Medicare patients cared for at Virginia Mason Hospital in 1986. HCFA statistics predicted that the number of Medicare patients who expired 30 days from admission to the hospital would fall between eight and 14 percent in 1986. Virginia Mason's actual Medicare mortality rate for that period was eight percent, the lowest in our predicted range.

Although the HCFA statistics indicate a low Medicare mortality rate for Virginia Mason, we agree with HCFA's consumer warning that <u>these statistics cannot be used for judging or comparing the actual quality of care</u> provided by different hospitals. We respect the efforts made by HCFA to help focus on quality assurance activities and appreciate the opportunity to comment on this informtion.

Sincerely,

Donnel R Olson

Don Olson
Administrator

925 Seneca Street
P.O. Box 1930
Seattle, WA 98111
Telephone (206) 624-1144

Whidbey General Hospital
P.O. Box 400 • Coupeville, Washington 98239-0400 • Tel. (206) 678-5151

October 21, 1987

TO: William L. Roper, M.D.
Administrator, Health Care Finance and Administration

FROM: Whidbey General Hospital - 500122

SUBJECT: Response to 1986 HCFA Mortality Report

Whidbey General Hospital reviewed the 1986 HCFA Mortality Report with the information it has available from its internal care evaluation program, which does review all deaths each month. The additional information from HCFA allowed us to glean some additional interesting and important insights. Thank you for the opportunity to add dimension to our existing quality review activities.

OVERALL MORTALITY RATE: The hospital's reported actual mortality rate of thirteen percent for selected diagnosises is within the reported predicted range of eight to seventeen percent.

DIAGNOSTIC CATEGORIES: The information was reviewed to identify two things; first, any specific diagnostic categories outside the hospitals predicted rate which should be evaluated more closely, and second; to determine if the hospital standard for condition stabilization, discharge planning and arrangements for continuity of care were present for those patients on the report who expired outside the hospital within 30 days of their admission. Special attention was focused on death occurring within one to five days after their discharge. There was only one category outside the predicted rate and this was cancer, which at eight percent was two percent below the lowest level predicted for the hospital. The hospital has a Tumor Registry and a Tumor Program accredited by the American College of Surgeons. The hospital has a Home Health Care department and a full time Social Service department, which works closely with the clinical staff and three geographically close extended care facilities to help meet cancer patient and family needs. In the last year an oncology nurse specialist, who also works in Home Health Care, came on staff and a support care room for patient and family support, when death is imminent, is now available. These factors along with the hospital's investigative plan for adding an oncology service, may cause this rate to increase in the future. The lower rate at this time, is consistent with the services available for cancer patients in our community. All other categories were within predicted levels, nevertheless, three categories with mortality rate in the middle upper end of the predicted range have been selected for continued close review in the hospital's internal care evaluation program. These will include strokes, severe heart disease and pulmonary disease. Being one of the more rapidly growing geriatric communities in the state of Washington, and knowing the hospital's more frequent diagnosises, maintaining a close review in these diagnostic categories will help to continue improving existing discharge planning and patients/family education programs.

DEATHS AFTER DISCHARGE: Those patients who died after discharge, had discharge planning arrangements in line with documented patient and/or family wishes or patient condition. One in the acute heart category was transferred to another

hospital for a specific treatment. The remaining were under skilled nursing care either at a extended or nursing home facility or were under Home Health Care services.

DEATHS IN LOW RISK CATEGORY: The care reviewed reaffirmed awareness that as a growing rural community hospital, with a steady increase in the geriatric age population per state statistics, and having approximately half inpatient admissions being Medicare patients, that chronic underlying diseases are frequently present when an acute problem is presenting and being treated. This was the situation for the deaths reviewed in the low-risk category, where the cause of death was not a complication of diagnosis being treated, but an additional acute care situation for an existing chronic health problem, i.e., patient in recovery for an orthopedic repair experienced a cardiac episode.

SUMMARY: With the exception of some date and social security number differences, hospital and HCFA mortality information are compatible. Mortality trends provided by HCFA are also compatible with the hospitals internal care evaluation program, where no practitioner and/or disease specific care question has been identified through pattern analysis in place.

The hospital appreciates the opportunity to include HCFA mortality information in its care evaluation program.

Sincerely,

James Kirkpatrick, M.D.
Chief of Staff and Chairman
MQAC/MEC

Robert Zylstra
Hospital Administrator

MEMORIAL HOSPITAL
YAKIMA VALLEY MEMORIAL HOSPITAL

RICHARD W. LINNEWEH, JR.
President - Chief Executive Officer

October 22, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Re: 1986 Mortality Data for Medicare Patients
Hospital 500036

Dear HCFA Officials:

We believe that the data accurately reflects the mortality percentages by the categories listed. The date of death was inaccurate for some patients, however. Additionally, we have not verified total cases by category to make sure that the unduplicated counts are correct.

The hospital maintains a variety of programs to oversee quality of care, including quality assurance committees for each department of the medical staff, special conferences that focus on mortality and morbidity, and generic quality screening criteria. All deaths are reviewed as a part of our quality assurance program. We will continue to evaluate all quality of care issues and take appropriate steps to address identified problems.

We are pleased that the HCFA mortality screens do not show a cause for concern at our facility. We appreciate the opportunity to comment on the findings.

Sincerely,

R. W. Linneweh, Jr., FACHE

RWL/mh

2811 Tieton Drive, Yakima, Washington 98902
Phone (509) 575-8001

West Virginia

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ARACOMA MEDICAL FOUNDATION LOGAN WV 25601	WV-7 *	102	17	7-22	5	40	9-79	4	25	4-78	1	0	0-97	12	25	7-53	1	100	1-97	5	20	2-69	23	22	7-40
BECKLEY APPALACHIAN REG HO BECKLEY WV 25801	WV-8 *	860	12	7-14	42	26	8-35	31	42	15-46	26	23	7-39	47	13	12-36	33	42	21-54	14	43	8-52	68	25	10-31
BECKLEY HOSP BECKLEY WV 25801	WV-9 *	906	19	10-18	36	36	19-51	43	47	18-46	23	39	7-41	66	35	13-33	59	41	25-51	22	27	5-39	127	26	12-28
BLUEFIELD COMM HOSP BLUEFIELD WV 24701	WV-10	1635	11	8-15	130	32	18-37	51	16	16-41	26	15	7-39	59	27	14-36	69	39	28-52	30	17	8-39	160	16	12-26
BOONE MEMORIAL HOSPITAL MADISON WV 25130	WV-11 *	243	16	8-19	5	60	10-80	10	30	11-64	7	0	2-59	9	44	5-57	8	38	14-74	6	17	2-64	32	38	9-38
BRAXTON COUNTY MEMORIAL HO GASSAWAY WV 26624	WV-12 *	305	14	11-21	10	50	10-64	14	14	12-58	8	0	1-55	19	32	9-47	16	38	21-67	12	42	4-50	42	21	13-40
BROADDUS HOSP ASSN INC PHILIPPI WV 26416	WV-13 *	503	10	8-16	13	38	15-64	18	39	12-53	9	22	4-57	20	25	9-45	17	47	21-65	11	0	5-53	54	13	12-35
CABELL-HUNTINGTON HOSP HUNTINGTON WV 25701	WV-14	2345	14	9-16	169	33	18-35	100	31	20-39	43	16	8-33	120	20	15-30	98	40	28-49	64	17	8-30	170	19	13-27
CALHOUN GENERAL HOSPITAL C GRANTSVILLE WV 26147	WV-15 *	256	13	9-20	12	42	12-63	10	30	10-62	5	20	1-68	20	20	8-44	10	20	12-66	16	25	6-47	51	12	9-31
CAMDEN CLARK MEMORIAL HOSP PARKERSBURG WV 26105	WV-16 *	2492	15	10-16	185	29	19-36	117	38	21-39	48	25	9-34	114	25	16-33	93	38	28-49	52	15	10-35	218	25	16-29
CHARLESTON AREA MED CTR KA CHARLESTON WV 25302	WV-17	231	14	7-17	10	20	7-58	4	75	4-77	3	33	0-84	17	18	8-47	6	33	11-76	9	22	3-56	33	30	8-36
CHARLESTON AREA MEDICAL CT CHARLESTON WV 25325	WV-18	6420	11	8-15	477	23	18-32	219	33	21-35	157	17	11-27	248	26	17-29	274	33	30-44	112	15	11-30	373	19	15-26
CITY HOSPITAL MARTINSBURG WV 25401	WV-19	1183	14	9-16	90	33	17-39	54	24	19-43	20	5	5-39	61	31	13-34	67	48	26-50	26	27	8-42	78	15	11-30
DAVIS MEMORIAL HOSPITAL ELKINS WV 26241	WV-20 *	1367	10	9-16	78	13	13-34	49	27	17-43	38	13	10-38	83	25	15-34	63	37	27-52	24	29	9-44	123	17	12-28
ELIZABETH COPLIN LEONARD M BUCKHANNON WV 26201	WV-21 *	71	10	6-23	1	0	0-97	2	100	3-91	2	0	0-92	5	20	3-70	1	100	1-97	7	14	3-62	15	7	4-43
FAIRMONT GENERAL HOSPITAL FAIRMONT WV 26554	WV-22	1820	13	9-16	97	21	13-33	71	48	22-44	45	22	7-32	119	26	16-32	104	34	28-48	32	25	9-39	161	23	13-27
GRAFTON CITY HOSP GRAFTON WV 26354	WV-23 *	292	13	9-19	16	63	12-56	15	20	12-56	8	13	4-59	20	25	11-48	10	50	16-71	5	0	2-69	32	13	8-37
GRANT MEMORIAL HOSPITAL PETERSBURG WV 26847	WV-24 *	438	11	8-16	13	23	9-56	12	25	11-60	13	15	3-45	20	25	10-46	11	36	18-71	11	36	9-60	63	17	10-31
GUTHRIE MEM HOSP INC HUNTINGTON WV 25701	WV-25 *	83	8	7-22	3	33	1-82	3	33	3-82	.	.		7	14	4-63	4	25	6-81	1	100	1-97	21	10	7-41
HAMPSHIRE MEMORIAL HOSP ROMNEY WV 26757	WV-26 *	176	14	8-19	4	25	2-75	4	50	6-80	2	0	0-90	14	14	6-47	7	29	11-73	8	25	2-56	33	21	11-40
HERBERT J THOMAS MEM HOSP SOUTH CHARLESTON WV 25309	WV-27	2315	12	9-15	195	27	16-32	71	31	20-42	41	10	10-37	128	23	15-31	84	36	27-49	50	26	9-34	213	23	14-27
HOLDEN HOSPITAL HOLDEN WV 25625	WV-28 *	77	10	6-23	2	100	3-91	2	0	1-89	1	0	1-97	7	14	4-62	2	0	3-91	2	50	1-89	18	17	6-43
HUMANA HOSP GREENBRIER VAL RONCEVERTE WV 24970	WV-29	1030	14	9-16	50	36	14-40	66	27	18-41	36	19	6-33	44	32	12-38	52	31	24-51	25	8	5-37	103	23	13-30
HUMANA HOSP-ST LUKE'S BLUE BLUEFIELD WV 24701	WV-30	529	11	7-15	32	31	12-43	14	14	9-53	8	0	4-59	34	21	10-38	12	25	13-63	12	33	5-52	45	27	10-34
HUNTINGTON HOSP INC HUNTINGTON WV 25719	WV-31	500	9	6-14	15	47	5-47	8	25	7-63	5	0	1-68	25	12	9-41	20	30	16-56	13	38	5-50	51	12	7-29
JACKSON GENERAL HOSP RIPLEY WV 25271	WV-32 *	468	12	10-19	27	30	14-49	23	26	15-52	15	7	3-43	36	39	13-41	21	38	21-62	9	0	2-53	42	26	12-39

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ARACOMA MEDICAL FOUNDATION LOGAN WV 25601	1	0	0-99	.	.		.	.		.	.		6	0	0-82	6	17	0-69	.	.		9	11	0-52	.	.	
BECKLEY APPALACHIAN REG HO BECKLEY WV 25801	9	22	5-61	3	0	5-86	10	0	1-47	1	0	0-100	73	7	1-13	16	0	1-35	2	0	0-100	62	3	2-14	13	8	0-44
BECKLEY HOSP BECKLEY WV 25801	14	43	15-65	6	50	8-73	14	14	1-38	12	0	0-97	73	4	1-13	36	8	1-21	5	0	0-99	125	2	2-10	28	7	0-31
BLUEFIELD COMM HOSP BLUEFIELD WV 24701	5	0	1-71	16	31	14-59	49	8	4-23	49	0	0-33	180	4	3-10	79	3	1-14	11	0	0-96	137	4	2-9	106	2	0-8
BOONE MEMORIAL HOSPITAL MADISON WV 25130	4	0	2-77	10	10	11-65	1	0	0-100	.	.		21	10	1-28	18	11	1-32	1	0	0-100	32	6	1-20	5	0	0-100
BRAXTON COUNTY MEMORIAL HO GASSAWAY WV 26624	5	60	5-75	7	43	10-73	1	0	0-100	.	.		27	0	0-23	2	0	0-89	3	0	0-100	59	2	2-15	11	0	0-51
BROADDUS HOSP ASSN INC PHILIPPI WV 26416	3	33	4-86	7	29	11-74	8	0	0-54	.	.		64	2	1-14	18	0	2-35	6	0	0-100	54	2	2-15	19	0	0-49
CABELL-HUNTINGTON HOSP HUNTINGTON WV 25701	29	21	8-45	25	44	21-60	75	8	4-19	6	0	0-100	215	6	3-11	124	5	2-12	28	0	0-63	197	6	2-9	141	1	0-6
CALHOUN GENERAL HOSPITAL C GRANTSVILLE WV 26147	2	50	3-92	.	.		.	.		.	.		38	5	2-20	14	14	0-38	5	0	0-100	17	0	0-32	5	0	0-96
CAMDEN CLARK MEMORIAL HOSP PARKERSBURG WV 26105	16	19	14-62	29	52	20-57	80	11	4-19	14	0	0-95	333	7	3-9	135	4	2-12	35	0	0-54	165	5	2-10	178	2	1-6
CHARLESTON AREA MED CTR KA CHARLESTON WV 25302	2	0	3-91	1	0	0-97	4	0	0-76	13	0	0-100	21	10	1-28	7	0	0-77	4	0	0-100	14	0	0-37	10	10	0-81
CHARLESTON AREA MEDICAL CT CHARLESTON WV 25325	78	21	13-42	44	25	21-52	216	6	5-14	24	0	0-75	522	5	3-8	227	5	2-11	33	0	0-75	898	6	3-7	436	1	0-4
CITY HOSPITAL MARTINSBURG WV 25401	11	18	8-62	13	46	16-57	38	11	3-25	13	0	0-95	127	6	2-10	60	3	1-16	8	0	0-100	132	7	2-10	46	0	0-15
DAVIS MEMORIAL HOSPITAL ELKINS WV 26241	20	10	8-50	18	33	21-65	36	8	1-22	4	0	0-100	156	5	3-11	97	1	1-13	19	0	0-96	145	3	2-9	67	0	0-12
ELIZABETH COPLIN LEONARD M BUCKHANNON WV 26201	.	.		.	.		.	.		.	.		6	0	0-64	2	0	0-92	2	0	0-100	6	17	0-65	5	0	0-73
FAIRMONT GENERAL HOSPITAL FAIRMONT WV 26554	16	44	9-56	22	36	18-59	62	8	3-19	11	0	0-100	198	6	3-10	61	0	2-16	21	0	0-80	133	2	2-10	136	2	0-6
GRAFTON CITY HOSP GRAFTON WV 26354	9	44	7-64	3	67	3-84	12	0	2-43	.	.		29	0	2-24	6	0	0-68	5	0	0-100	19	0	1-30	17	0	0-47
GRANT MEMORIAL HOSPITAL PETERSBURG WV 26847	7	29	4-66	4	75	8-84	3	0	0-95	.	.		38	0	1-18	10	0	1-47	8	0	0-100	50	0	1-15	12	0	0-92
GUTHRIE MEM HOSP INC HUNTINGTON WV 25701	2	0	0-90	.	.		.	.		.	.		13	0	0-41	3	0	0-97	1	0	0-100	1	0	0-100	2	0	0-100
HAMPSHIRE MEMORIAL HOSP ROMNEY WV 26757	.	.		1	0	1-97	4	50	0-88	.	.		16	13	0-34	6	0	0-63	1	0	0-100	23	0	0-25	3	33	0-99
HERBERT J THOMAS MEM HOSP SOUTH CHARLESTON WV 25309	15	53	12-60	21	38	18-59	64	6	3-18	40	0	0-31	294	4	2-8	119	3	2-13	29	3	0-77	199	6	2-8	82	0	0-10
HOLDEN HOSPITAL HOLDEN WV 25625	.	.		.	.		.	.		.	.		5	0	0-69	4	0	0-75	.	.		23	4	0-25	3	0	0-100
HUMANA HOSP GREENBRIER VAL RONCEVERTE WV 24970	4	25	1-76	4	25	7-82	28	14	3-28	5	0	0-100	93	3	2-13	78	8	1-14	16	0	0-89	127	3	2-10	59	2	0-12
HUMANA HOSP-ST LUKE'S BLUE BLUEFIELD WV 24701	10	30	7-62	3	33	4-84	15	13	1-37	9	0	0-99	50	4	1-16	17	0	1-33	4	0	0-100	38	0	1-19	70	1	0-12
HUNTINGTON HOSP INC HUNTINGTON WV 25719	5	40	4-74	6	83	11-77	9	0	1-50	2	0	0-100	48	4	1-16	18	0	1-32	1	0	0-100	29	3	1-22	44	0	0-24
JACKSON GENERAL HOSP RIPLEY WV 25271	7	29	13-77	4	50	10-86	.	.		1	0	0-100	64	2	1-14	32	0	0-23	6	17	0-97	31	3	1-22	16	0	0-48

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																							
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
JEFFERSON MEMORIAL HOSPITA RANSON WV 25438	WV-33 *	504	14	9-17	32	28	10-40	23	43	14-51	18	28	7-46	34	29	12-40	26	42	21-58	13	8	3-45	47	26	11-35
LOGAN GENERAL HOSP LOGAN WV 25601	WV-34 *	1161	14	10-17	39	56	21-52	43	30	17-45	27	19	8-40	58	22	13-35	56	39	22-48	37	16	8-37	154	18	14-29
MAN APPALACHIAN REGIONAL H MAN WV 25635	WV-35 *	169	8	7-18	4	25	6-80	12	42	11-60	1	0	0-97	12	8	4-48	5	40	8-78	3	0	1-81	28	7	6-35
MEMORIAL GENERAL HOSP ELKINS WV 26241	WV-36 *	65	9	3-19	5	0	1-68	1	100	1-97	4	0	0-76	3	0	2-82	.	.		1	0	0-98	5	40	1-68
MONONGALIA CO GENERAL HOSP MORGANTOWN WV 26505	WV-37	2160	11	9-15	139	22	17-35	76	33	19-40	39	21	7-34	114	23	16-32	81	46	28-50	41	34	13-42	177	18	12-26
MONTGOMERY GENERAL HOSPITA MONTGOMERY WV 25136	WV-38 *	721	12	9-16	23	35	19-58	27	22	13-46	9	22	1-52	37	14	12-39	34	47	23-56	16	13	4-43	106	15	12-28
MORGAN CO WAR MEM HOSP BERKELEY SPRINGS WV 25411	WV-39 *	205	21	9-21	13	31	6-51	5	40	8-78	8	38	2-55	19	32	9-46	7	57	12-75	13	23	7-54	26	35	8-39
OHIO VALLEY GENERAL HOSPIT WHEELING WV 26003	WV-40	2098	11	8-15	169	27	17-34	74	31	18-39	38	11	7-33	91	29	15-33	79	43	28-50	30	17	10-43	165	19	14-28
PETERSON HOSP WHEELING WV 26003	WV-41 *	1	0	0-98	.	.		.	.		.	.		.	.		.	.		1	0	0-98	.	.	
PLATEAU MEDICAL CENTER OAK HILL WV 25901	WV-42	620	17	9-16	30	50	14-47	29	31	16-49	18	33	6-43	30	30	9-38	22	59	19-58	12	25	3-48	75	24	10-30
PLEASANT VALLEY HOSPITAL POINT PLEASANT WV 25550	WV-43	759	15	9-17	36	39	21-53	26	54	16-51	23	26	9-44	44	41	12-37	26	42	21-57	16	25	4-43	79	27	12-31
POCAHONTAS MEM HOSP MARLINTON WV 24954	WV-44	228	17	13-24	5	80	13-83	10	50	9-61	4	25	5-79	15	40	11-55	6	33	15-81	23	4	6-40	55	25	14-38
POTOMAC VALLEY HOSP KEYSER WV 26726	WV-45 *	440	12	9-17	16	31	10-54	19	21	13-52	9	11	3-54	40	23	10-36	23	48	20-58	14	14	2-44	48	4	9-32
PRESTON MEMORIAL HOSP KINGWOOD WV 26537	WV-46 *	370	15	9-18	16	31	5-45	18	28	12-52	10	20	6-57	15	27	8-49	14	64	17-65	6	0	1-63	41	29	13-40
PRINCETON COMMUNITY HOSP PRINCETON WV 24740	WV-47 *	1906	10	7-14	117	32	19-38	72	28	18-39	27	15	7-38	82	16	14-33	56	38	25-52	27	11	7-39	112	26	14-31
PUTNAM GENERAL HOSPITAL HURRICANE WV 25526	WV-48	533	15	10-19	28	29	10-43	18	33	12-53	5	0	1-68	36	11	11-38	34	44	23-55	7	43	2-61	72	26	13-34
RALEIGH GENERAL HOSP BECKLEY WV 25801	WV-49	2129	14	8-15	147	33	18-37	81	40	18-39	46	24	8-32	121	25	15-31	92	43	27-48	45	27	8-35	161	24	12-26
REYNOLOS MEM HOSP GLEN OALE WV 26038	WV-50 *	1182	13	9-16	85	34	19-41	39	36	15-43	22	27	5-39	74	24	14-34	45	53	25-54	14	14	5-47	109	18	11-27
ROANE GEN HOSP SPENCER WV 25276	WV-51	563	12	9-17	14	43	17-66	23	43	15-52	16	19	3-41	38	29	11-38	18	39	19-61	11	36	7-57	76	17	11-31
SACREO HEART HOSPITAL RICHWOOO WV 26261	WV-52 *	201	14	8-19	9	44	6-60	11	27	9-59	7	0	2-60	16	31	9-51	6	67	9-74	7	0	3-62	26	23	11-45
SISTERVILLE GENERAL HOSP SISTERSVILLE WV 26175	WV-53 *	150	18	8-21	6	83	10-76	1	0	1-97	3	0	1-81	6	33	3-64	8	50	13-73	7	0	6-66	21	29	9-45
SOUTH CHARLESTON COMM HOSP SOUTH CHARLESTON WV 25303	WV-54 *	191	7	5-15	6	33	7-72	3	33	5-85	7	14	3-61	6	17	4-66	4	0	6-81	7	14	1-59	19	5	5-40
ST FRANCIS HOSP CHARLESTON WV 25301	WV-55 *	1610	9	9-15	160	26	19-37	27	15	14-48	32	22	11-41	78	19	14-33	36	22	24-56	26	19	10-44	191	16	13-27
ST JOSEPH HOSPITAL BUCKHANNON WV 26201	WV-56*	529	10	7-15	18	28	8-47	16	38	11-53	13	15	4-47	19	26	8-45	21	33	22-63	18	28	7-46	35	11	9-36
ST JOSEPHS HOSP PARKERSBURG WV 26101	WV-57	2402	10	8-14	150	18	19-37	91	30	20-40	43	14	5-28	109	25	16-33	92	30	28-50	64	17	9-32	174	24	12-26
ST MARYS HOSP HUNTINGTON WV 25701	WV-58	3330	13	9-15	338	30	20-34	120	28	18-35	54	19	9-32	151	28	15-30	159	40	28-45	44	30	6-32	232	24	14-28

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
JEFFERSON MEMORIAL HOSPITA RANSON WV 25438	7	14	4-65	1	0	0-97	17	6	1-34	9	0	0-100	60	2	1-15	18	6	0-33	7	0	0-100	45	7	1-17	14	0	0-74
LOGAN GENERAL HOSP LOGAN WV 25601	14	7	8-56	15	53	18-65	27	7	2-27	.	.		105	9	2-13	68	4	1-15	4	0	0-100	194	3	2-9	38	3	0-21
MAN APPALACHIAN REGIONAL H MAN WV 25635	.	.		1	0	1-97	2	50	0-97	.	.		20	10	1-29	.	.		1	0	0-100	28	0	1-22	5	0	0-95
MEMORIAL GENERAL HOSP ELKINS WV 26241	1	100	0-99	1	0	1-97	.	.		.	.		7	14	0-60	4	0	0-93	.	.		15	0	0-39	5	0	0-99
MONONGALIA CO GENERAL HOSP MORGANTOWN WV 26505	9	22	7-63	27	44	25-63	76	11	4-19	16	0	0-95	220	5	3-10	81	2	1-13	30	0	0-95	215	4	2-8	197	2	0-5
MONTGOMERY GENERAL HOSPITA MONTGOMERY WV 25136	11	9	7-60	3	67	5-85	23	0	1-28	3	0	0-100	81	9	2-14	38	0	1-20	8	0	0-100	109	3	2-11	33	3	0-34
MORGAN CO WAR MEM HOSP . BERKELEY SPRINGS WV 25411	12	33	6-57	1	100	1-97	.	.		.	.		20	10	0-29	6	0	0-68	2	0	0-100	24	0	1-26	5	0	0-100
OHIO VALLEY GENERAL HOSPIT WHEELING WV 26003	15	27	5-50	24	46	18-57	66	6	3-17	15	0	0-96	160	3	3-11	82	4	1-13	16	0	0-98	127	5	2-10	135	1	0-6
PETERSON HOSP WHEELING WV 26003	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
PLATEAU MEDICAL CENTER OAK HILL WV 25901	8	0	4-62	5	60	11-82	14	21	1-38	.	.		76	11	2-14	40	23	2-21	2	0	0-100	84	1	2-12	20	0	0-52
PLEASANT VALLEY HOSPITAL POINT PLEASANT WV 25550	14	14	7-54	8	13	9-68	14	7	1-38	4	0	0-100	82	4	2-13	42	5	1-19	9	0	0-99	110	3	2-11	23	9	0-27
POCAHONTAS MEM HOSP MARLINTON WV 24954	11	27	10-64	2	50	6-94	1	0	0-98	.	.		10	0	0-47	3	33	0-88	.	.		22	0	0-26	9	0	0-61
POTOMAC VALLEY HOSP KEYSER WV 26726	7	43	5-67	3	33	6-87	3	0	0-85	.	.		68	6	2-14	10	10	0-48	1	0	0-100	45	2	1-17	8	0	0-74
PRESTON MEMORIAL HOSP KINGWOOD WV 26537	7	43	5-67	5	20	9-79	7	14	1-58	.	.		46	2	1-17	6	33	0-70	.	.		42	10	1-17	3	0	0-99
PRINCETON COMMUNITY HOSP PRINCETON WV 24740	22	5	5-44	7	29	10-72	65	8	3-19	15	7	0-94	191	4	3-10	113	6	2-14	18	0	0-69	183	6	2-9	181	1	0-5
PUTNAM GENERAL HOSPITAL HURRICANE WV 25526	9	22	10-69	10	50	13-68	22	5	3-32	.	.		44	2	1-17	33	3	2-25	3	0	0-100	44	7	1-16	13	8	0-49
RALEIGH GENERAL HOSP BECKLEY WV 25801	20	20	5-46	19	42	18-61	71	6	3-17	98	2	0-12	236	6	2-8	114	7	1-12	24	0	0-89	229	4	2-8	82	0	0-11
REYNOLDS MEM HOSP GLEN DALE WV 26038	7	57	4-65	9	33	13-70	23	9	2-29	2	0	0-100	117	3	2-11	65	2	1-15	8	0	0-100	142	4	2-10	57	0	0-13
ROANE GEN HOSP SPENCER WV 25276	4	50	3-77	.	.		3	0	0-83	1	0	0-100	67	3	2-14	22	5	2-30	4	0	0-100	58	5	2-15	29	0	0-28
SACRED HEART HOSPITAL RICHWOOD WV 26261	3	33	3-84	2	0	2-90	1	0	0-100	.	.		23	4	0-26	9	0	0-54	4	0	0-100	26	0	1-24	6	17	0-99
SISTERVILLE GENERAL HOSP SISTERSVILLE WV 26175	4	50	2-76	1	0	2-98	.	.		.	.		21	5	1-29	4	0	1-74	1	0	0-100	14	7	0-37	8	13	0-87
SOUTH CHARLESTON COMM HOSP SOUTH CHARLESTON WV 25303	1	0	0-99	1	0	0-97	.	.		.	.		29	7	1-22	1	0	0-100	.	.		17	6	0-32	24	0	0-41
ST FRANCIS HOSP CHARLESTON WV 25301	15	20	8-56	4	25	5-79	12	17	2-44	57	0	0-23	161	4	2-10	119	3	2-13	22	5	0-36	125	3	2-10	55	0	0-14
ST JOSEPH HOSPITAL BUCKHANNON WV 26201	3	0	2-83	5	60	10-80	15	0	1-36	5	0	0-100	50	6	1-16	5	40	0-73	11	0	0-97	64	2	1-13	20	0	0-43
ST JOSEPHS HOSP PARKERSBURG WV 26101	26	35	11-50	15	13	14-61	64	5	2-17	13	0	0-96	294	6	2-8	135	4	1-12	35	0	0-87	162	6	2-9	198	0	0-5
ST MARYS HOSP HUNTINGTON WV 25701	28	11	10-48	28	39	21-58	108	4	3-16	33	0	0-49	262	6	2-9	209	4	1-10	28	0	0-90	350	3	2-7	168	2	0-6

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
STEVENS CLINIC HOSP WELCH WV 24801	WV-59 *	410	18	10-19	18	50	13-55	15	20	10-53	15	13	2-41	26	27	8-38	22	50	22-62	14	36	6-49	60	28	12-35
STONEWALL JACKSON MEM HOSP WESTON WV 26452	WV-60	578	11	8-17	9	56	11-67	26	35	17-52	15	13	3-43	51	20	14-38	21	33	21-61	13	15	4-48	61	15	11-33
SUMMERS COUNTY HOSPITAL HINTON WV 25951	WV-61 *	474	15	10-18	15	60	11-56	20	25	17-57	15	13	3-43	33	21	13-43	15	53	16-62	17	12	6-45	73	22	12-32
SUMMERVILLE MEMORIAL HOSP SUMMERSVILLE WV 26651	WV-62 *	253	11	8-18	7	86	14-77	13	23	10-56	15	13	6-47	7	14	4-63	10	40	15-70	6	0	3-65	30	13	7-36
THE EYEEAR CLINIC OF CHAR CHARLESTON WV 25301	WV-63 *	228	1	0-10	2	0	1-89	.	.		.	.		.	.		.	.		1	100	1-97	.	.	
TUCKER CO HOSP PARSONS WV 26287	WV-64 *	122	9	5-18	2	100	2-90	3	33	3-84	4	0	2-74	4	25	6-80	9	56	16-73	2	0	0-93	2	50	1-89
UNITED HOSP CTR INC CLARKSBURG WV 26301	WV-65	3251	13	10-16	281	26	20-35	136	34	22-39	66	21	10-32	206	28	18-31	103	49	27-47	57	14	10-35	270	16	13-25
WEBSTER CTY MEMORIAL HOSP WEBSTER SPRINGS WV 26288	WV-66 *	154	21	9-21	3	67	0-82	10	40	11-65	1	0	0-99	9	33	5-58	11	18	14-66	6	50	4-67	22	55	12-48
WEIRTON MED CTR 601 COLLIE WEIRTON WV 26062	WV-67 *	1637	12	8-15	82	23	14-36	56	34	18-42	27	37	11-44	90	24	15-33	32	38	23-57	30	20	9-40	206	19	13-26
WEIRTON OSTEOPATHIC HOSPIT WEIRTON WV 26062	WV-68	75	8	5-20	3	33	4-84	2	0	2-89	2	0	0-92	5	20	2-69	.	.		1	0	0-98	20	10	5-40
WELCH EMERGENCY HOSPITAL WELCH WEST VIRGINA 24801	WV-69 *	98	17	7-22	4	25	4-78	2	0	2-89	2	0	0-91	7	14	6-65	3	100	6-87	3	0	1-81	16	19	5-43
WEST VIRGINIA UNIV HOSP MORGANTOWN WV 26506	WV-70	2335	14	9-15	216	28	22-38	52	44	17-43	45	16	10-36	81	38	16-35	68	46	29-53	36	19	11-41	115	27	13-30
WETZEL CO HOSP NEW MARTINSVILLE WV 26155	WV-71 *	563	13	10-18	30	47	20-54	22	36	14-52	15	0	3-41	46	22	12-36	25	44	20-57	22	9	7-42	65	18	11-32
WHEELING HOSP WHEELING WV 26003	WV-72	2728	11	8-15	184	28	17-34	96	22	18-36	50	12	5-28	129	29	15-30	106	48	29-49	48	13	10-36	234	18	14-27
WILLIAMSON MEMORIAL HOSPIT WILLIAMSON WV 25661	WV-73 *	381	17	8-17	5	100	7-76	10	50	11-64	3	33	3-83	24	33	11-45	19	63	16-58	27	11	8-40	35	31	9-36
WYOMING GENERAL HOSP MULLENS WV 25882	WV-74	114	11	5-18	1	100	1-97	.	.		3	0	2-82	2	50	1-89	8	63	9-67	5	0	1-68	23	9	4-35

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
STEVENS CLINIC HOSP WELCH WV 24801	3	0	1-83	9	44	17-75	3	33	0-90	.	.		49	14	1-16	4	25	0-77	1	0	0-100	76	1	1-12	1	0	0-100
STONEWALL JACKSON MEM HOSP WESTON WV 26452	4	25	3-78	4	0	3-76	26	0	2-27	.	.		45	4	2-18	41	0	0-19	7	0	0-100	79	1	1-12	27	4	0-27
SUMMERS COUNTY HOSPITAL HINTON WV 25951	4	25	4-79	6	17	6-71	7	43	1-57	.	.		35	3	1-19	11	9	0-47	.	.		69	4	2-13	20	0	0-39
SUMMERVILLE MEMORIAL HOSP SUMMERSVILLE WV 26651	7	14	3-64	1	0	0-97	3	0	0-83	1	0	0-100	16	13	0-34	7	0	1-57	1	0	0-100	33	6	1-20	5	0	0-97
THE EYEEAR CLINIC OF CHAR CHARLESTON WV 25301	.	.		.	.		.	.		128	1	0-6	1	0	0-100	.	.		.	.		1	0	0-100	.	.	
TUCKER CO HOSP PARSONS WV 26287	.	.		.	.		.	.		.	.		13	0	0-39	1	0	0-100	1	0	0-100	10	0	0-48	11	0	0-89
UNITED HOSP CTR INC CLARKSBURG WV 26301	33	36	11-47	19	11	15-58	85	12	5-20	13	0	0-91	379	6	3-9	176	3	2-11	31	3	0-32	315	4	3-8	130	2	0-7
WEBSTER CTY MEMORIAL HOSP WEBSTER SPRINGS WV 26288	1	100	3-99	.	.		2	0	0-97	.	.		12	0	0-41	3	0	0-85	.	.		23	0	0-26	5	0	0-100
WEIRTON MED CTR 601 COLLIE WEIRTON WV 26062	19	53	12-56	16	31	12-57	18	22	2-34	12	0	0-97	162	6	2-10	88	7	2-15	25	8	0-65	205	4	2-8	69	0	0-11
WEIRTON OSTEOPATHIC HOSPIT WEIRTON WV 26062	1	100	2-99	.	.		.	.		.	.		2	0	0-99	1	0	0-100	1	0	0-100	3	0	0-99	13	0	0-87
WELCH EMERGENCY HOSPITAL WELCH WEST VIRGINA 24801	2	0	1-90	3	67	8-89	.	.		.	.		6	0	0-75	6	50	1-63	.	.		8	0	0-57	2	0	0-100
WEST VIRGINIA UNIV HOSP MORGANTOWN WV 26506	49	31	13-45	14	71	16-64	41	17	4-24	158	0	0-5	120	7	4-15	77	4	1-14	20	0	0-30	217	11	3-10	137	2	0-6
WETZEL CO HOSP NEW MARTINSVILLE WV 26155	2	0	0-90	3	33	4-85	3	0	0-83	.	.		73	3	2-14	17	6	0-34	1	0	0-100	53	4	1-15	15	0	0-51
WHEELING HOSP WHEELING WV 26003	24	29	8-48	42	38	23-55	54	6	3-20	113	1	0-10	248	5	2-9	100	4	1-13	38	0	0-63	329	2	2-7	216	3	0-5
WILLIAMSON MEMORIAL HOSPIT WILLIAMSON WV 25661	6	50	7-73	4	75	6-81	10	10	1-47	.	.		29	7	1-23	16	0	2-37	4	0	0-100	61	2	1-14	9	0	0-96
WYOMING GENERAL HOSP MULLENS WV 25882	1	0	0-99	.	.		.	.		.	.		10	0	0-53	1	0	0-100	.	.		22	5	1-27	3	0	0-100

*Written Comments Not Submitted.

Bluefield Community Hospital
500 Cherry St. • Bluefield, West Virginia 24701 • (304) 327-2511

OCTOBER 26, 1987

WILLIAM L ROPER, M. D., ADMINISTRATOR
HEALTH CARE FINANCE ADMINISTRATION
HEALTH STANDARDS & QUALITY BUREAU
HOSPITAL MORTALITY INFORMATION
P. O. BOX 26684
BALTIMORE, MARYLAND 21207

DEAR DOCTOR ROPER:

WE HAVE REVIEWED OUR MORTALITY PROFILE AS WELL AS THE INFORMATION PUBLISHED IN THE AUGUST 17, 1987 FEDERAL REGISTER. WE HAVE ALSO VERIFIED THE LISTING OF DEATHS PROVIDED. WHILE WE HAVE NO COMPLAINT WITH THE DATA ITSELF, AS ONLY ONE CASE WAS NOTED TO HAVE AN INCORRECT PRINCIPAL DIAGNOSIS, WE FAIL TO UNDERSTAND HOW THIS STATISTICAL DATA CAN BE INTERPRETED AS A MEASURE OF QUALITY CARE AND FEEL THAT PUBLICATION OF THIS DATA WILL NOT BE BENEFICIAL TO PATIENTS.

AT BEST, WE FEEL YOUR COMMENTS AS PUBLISHED IN THE FEDERAL REGISTER SUM UP THE VALIDITY AND USEFULNESS OF THE DATA: "WE REALIZE, HOWEVER, THAT OUR MODEL FOR PREDICTING A PARTICULAR HOSPITAL'S EXPECTED MORTALITY RATE IS LIMITED BY THE KINDS OF INFORMATION AVAILABLE TO US ON MEDICARE BILLS AND GENERAL INFORMATION ON THE HOSPITALS INVOLVED. THE MODEL REMAINS SIMPLY ONE INDICATOR OF <u>POTENTIAL</u> QUALITY DISTINCTIONS AMONG HOSPITALS". ANOTHER STATEMENT INCLUDED IN THE FEDERAL REGISTER SHOULD BE POINT TO PATIENTS AS FOLLOWS: "FIRST, NOT ALL OF THE FACTORS AFFECTING THE PROBABILITY OF DEATH IN A PARTICULAR CASE, MOST NOTABLY SEVERITY OF ILLNESS, ARE INCLUDED IN THE PREDICTIVE MODEL BECAUSE INFORMATION ON THEM IS NOT READILY AVAILABLE. THUS, A DIFFERENCE BETWEEN A HOSPITAL'S ACTUAL AND EXPECTED MORTALITY RATES CANNOT BE DEFINITELY CONSTRUED AS REFLECTING ESPECIALLY HIGH OR LOW QUALITY OF CARE."

REGARDING THE PRESENTATION OF THE DATA RECEIVED, WE FIND THE RATES AND CATEGORY DENOTED AS "ALL CAUSES" BE MISLEADING. THE CATEGORY SHOULD BE DENOTED AS "ALL <u>OTHER</u> CAUSES" AS THE SPECIFIED CATEGORIES ARE NOT INCLUDED IN THE "ALL CAUSES" CATEGORY. THUS, OVERALL MORTALITY RATES FOR ALL FACILITIES WOULD BE MORE REALISTIC. AS AN EXAMPLE, OUR FACILITY'S OVERALL MORTALITY RATE WOULD BE CALCULATED AS 7%.

Bluefield Community Hospital
500 Cherry St. • Bluefield, West Virginia 24701 • (304) 327-2511

WHILE WE UNDERSTAND THE METHODOLOGY OF YOUR CATEGORIZATION, WE FEEL THE INFORMATION WOULD HAVE BEEN MORE MEANINGFUL IF REPORTED BY DRG. AS AN EXAMPLE, THE CATEGORY "SEVERE ACUTE HEART DISEASE" INCLUDES MYOCARDIAL INFARCTION, CARDIAC DYSRYHTHYMIAS AND ANEURYSMS. WHILE IT IS TRUE THAT ALL THE PATIENTS HAVE A SEVERE ACUTE CONDITION, THE TYPE OF CARE NECESSARY TO TREAT THE CONDITION VARIES SIGNIFICANTLY. IF THE INFORMATION WERE PRESENTED BY DRG, PATIENTS WOULD HAVE BEEN GROUPED MORE APPROPRIATELY AS COMORBID CONDITIONS AND COMPLICATIONS COULD HAVE BEEN RECOGNIZED AS WELL AS THE DIFFERENT TREATMENT REGIMENS NECESSARY TO CARE FOR A GIVEN TYPE PATIENT. IN OUR REVIEW OF THE DATA, WE FOUND THAT THE AVERAGE PATIENT HAD SIX ADDITIONAL DISEASE PROCESSES THAT WERE ACTIVELY TREATED DURING THE ADMISSION.

MANY FACTORS INFLUENCE A HOSPITAL'S MORTALITY RATE, ESPECIALLY THE SEVERITY OF ILLNESS, AS A WHOLE, CARED FOR BY THE FACILITY. AS AN EXAMPLE, THE CANCER CATEGORY. OUR FACILITY IS THE ONLY FACILITY IN OUR AREA THAT PROVIDES BOTH RADIATION AND CHEMOTHERAPY. THEREFORE, WE RECEIVE A SIGNIFICANT NUMBER OF PATIENTS IN TRANSFER FROM SURROUNDING FACILITIES. OUR AREA DOES NOT HAVE ACCESS TO A HOSPICE PROGRAM.

BLUEFIELD COMMUNITY HOSPITAL IS THE LARGEST HOSPITAL IN THE REGION. WE ARE STRIVING TO MEET THE NEEDS OF OUR COMMUNITY CONTINUALLY. WE HAVE THE HIGHEST CASE MIX INDEX IN OUR AREA AND PROVIDE MANY VARIED SERVICES. PUBLICATION OF THIS TYPE DATA COULD BE VERY EASILY MISINTERPRETED BY THE AVERAGE PATIENT. WE HOPE HCFA WILL FOCUS ON THE EDUCATION OF THE PUBLIC FOLLOWING RELEASE OF THIS INFORMATION.

WE APPRECIATE THE OPPORTUNITY TO COMMENT PRIOR TO THE PUBLICATION OF THIS DATA.

TERRY L. JONES
ADMINISTRATOR

CABELL HUNTINGTON HOSPITAL

October 23, 1987

William L. Roper, M.D.
Administrator,
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper,

We have examined the 1986 Medicare Mortality Data for Cabell Huntington Hospital. Attached are our comments for enclosure when the data is published, as well as a listing of discrepancies found in comparing the hospital medical record with your reported data.

I would reemphasize that while this hospital's mortality rate was within the predicted range, the use of mortality data alone should not be considered a valid quality indicator. Many additional factors must be considered before such judgments may be accurately made. Publication of unverified and unvalidated data may lead the public to make erroneous judgments regarding a particular institutions quality of care.

If you have any questions, please contact me at (304) 526-2052.

Sincerely,

Donald H. Hutton,
President

Enclosure

cc: Kenneth Rutledge, President WVHA
Robert C. Byrd, U.S. Senator
John D. Rockefeller IV, U.S. Senator
Nick J. Rahall II, U.S. Representative

1340 Hal Greer Boulevard, Huntington, West Virginia 25701-0195 304/526-2000

CABELL HUNTINGTON HOSPITAL

October 21, 1987

COMMENTS ON THE HCFA MORTALITY DATA:
CABELL HUNTINGTON HOSPITAL
HUNTINGTON, WEST VIRGINIA
MEDICARE PROVIDER # 510055

The data used by HCFA indicate that a total of 2,345 Medicare patients were admitted to Cabell Huntington Hospital in 1986. Our records indicate that 3,847 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries. We have no way of verifying whether the number of Medicare patients treated at Cabell Huntington Hospital is correct. The data used by HCFA indicate that a total of 326 Medicare patients admitted to Cabell Huntington Hospital died within 30 days of admission. Of these, 267 died while still a patient of the hospital, while 59 died after discharge. Our records show that of the 59 patients reported by HCFA with dates of death after discharge from the hospital, but within 30 days of admission, 50 were actually discharged alive, while 9 of the patients died inhospital. It is impossible to determine if all of the 50 patients who were in fact alive at discharge have died or are still alive as information concerning death after discharge from the hospital is not included in the patients' medical record.

Without detailed information concerning the billing data used in the HCFA analysis to compute the predicted mortality rate, it is impossible to verify the accuracy of diagnostic or other data used in the HCFA analysis.

Cabell Huntington Hospital's mortality rate as computed by HCFA falls within the predicted range of mortality in all of the 16 diagnostic categories. In fact Cabell Huntington Hospital's mortality rate is below the midpoint in 11 of 16 (69%) categories.

Cabell Huntington Hospital is a teaching, tertiary care hospital with many patients referred from other facilities. We feel that our level of tertiary care services significantly affects the patient mortality rates. Approximately 7% of those Medicare deaths had been referred from other facilities. The hospital operates a Trauma Service with onsite helicopter for transport of critically ill or injured patients. The Burn Unit, Kidney Dialysis Unit, Oncology Unit and Hospice care at Cabell Huntington Hospital

also bring in patients who can be expected to have a higher mortality rate. The special services, referrals, seriousness of the patients' condition and average age underscore that many of these patients came to the hospital for their terminal care, with death the expected outcome. The average age of the Medicare patients who died at Cabell Huntington Hospital was 79. The HCFA methodology took in to account only the presence of one comorbidity in calculating expected mortality, while the patients reported for Cabell Huntington Hospital had an average of four(4) significant comorbidities. Patients in this group suffered from multiple chronic disease states with these comorbidities impacting length of stay and mortality rates.

When these factors are examined one can see that many other criteria must be considered in placing this in proper perspective. Many agencies consider the validity of mortality data to be questionable in evaluating the quality of care.

We are concerned with the reporting of unverified data which has many errors. The 326 cases reported for Cabell Huntington Hospital had 26 cases with errors, an overall error rate of 8%. The complete listing of errors, submitted to HCFA(Attachment 1), includes errors in principal diagnosis, dates of death and multiple listing of patients. Data on patients who are reported to have died out of hospital has the highest error rate and in our opinion should be eliminated from the study. The data as presented is flawed and represents only a preliminary tabulation. It is impossible to validate this data without the detailed information used by HCFA in compiling this study.

The data reported by HCFA is a beginning point for review and does not in any way accurately measure the quality of care rendered at this hospital or any other. The preliminary studies indicate that death was to be expected in most of the patients reported here. Ongoing studies must be conducted to evaluate the patient care rendered before an accurate quality of care evaluation may be made.

Attachment 1

CHH ERRORS IN HCFA REPORTED MORTALITY

HIC NUMBER	NAME	ERROR	CORRECT DATA
[redacted]	[redacted]	Reported Age [redacted]	[redacted]
		Reported Age 84	85
		Prin. Dx 436	410.9
		Rep. Death Date 10/8	10/7/86
		Duplicate entries	
		Duplicate entries	
		Prin. Dx. 428	410.9
		Date of Death 12/31/86	12/25/86
		Prin. Dx 425.4	410.7
		Prin. Dx. 428.1	410.9
		Date of Death 1/21/86	1/20/86
		Date of Death 7/31/87	7/8/87
		Prin. Dx. 715.96	410.9
		Prin. Dx. 510.9	162.9
		Date of Death 10/31/86	10/26/86
		Prin. Dx. 486	410.9
		Date of Death 6/30/86	6/28/86
		Prin. Dx. 820.21	410.1
		Date of Death 2/28/86	2/15/86
		Date of Death 4/22/86	4/27/86
		Date of Death 3/31/86	3/30/86
		Prin. Dx. 280.9	410.7
		Last Disch. 1/2/86	Actual 1/17/86 Died inhouse
		Age 73	74
		Age 72	74
		Prin. Dx. 250.91	191.3
		Date of Death 7/2/86	7/6/86

CHARLESTON AREA MEDICAL CENTER
501 Morris Street • P.O. Box 1547
Charleston, West Virginia 25326 • 304/348-7627

FACILITY: CHARLESTON AREA MEDICAL CENTER - KANAWHA DIV
MEDICARE PROVIDER NUMBER: 510052

The data for the Charleston Area Medical Center Kanawha Division provides data from Kanawha Valley Memorial Hospital. This institution was merged with the Charleston Area Medical Center in September of 1986. The Kanawha Valley Division of the Charleston Area Medical Center will be the first Women and Children's Center in West Virginia. The mortality data provided by HCFA is not pertinent to the new Kanawha Valley Division and represents information from a no longer existing facility.

CHARLESTON AREA MEDICAL CENTER
501 Morris Street • P.O. Box 1547
Charleston, West Virginia 25326 • 304/348-7627

FACILITY: CHARLESTON AREA MEDICAL CENTER
MEDICARE PROVIDER NUMBER: 510022

The Charleston Area Medical Center (CAMC), West Virginia's largest and most comprehensive health care facility, is a 962 bed, voluntary not-for-profit health care organization. CAMC is both a general hospital and a regional referral center. Our committment to the community and our state is evidenced by the large amount of charity care provided by our institution. CAMC is a teaching facility which provides not only primary health care but also provides highly specialized services. CAMC provides comprehensive emergency services and emergency medical helicopter service. CAMC's Heart Institute is a major regional center for the treatment of heart disease including open heart surgery. Through the Cancer Care Center of Southern West Virginia, CAMC offers the most advanced treatment available to cancer patients.

CAMC also offers the highest technology level in the diagnosis and treatment of diseases. We offer such diagnostic tools as Magnetic Resonance Imaging (MRI), and sophisticated treatment methodologies such as Extracorporeal Shock Wave Lithotripsy. In addition, the first kidney transplant in southern West Virginia was recently performed at CAMC. Because CAMC is a highly sophisticated technologically advanced medical center, and provides the most advanced diagnostic tools and treatment modalities, the severity of illness level of our patient mix is high.

The HCFA mortality data provides a range of predicted rates for various categories. These ranges are crucial to the use of the data. The predicted range takes into account some variations of patient mix of the institution and is necessary to the understanding of the data.

We have attempted to verify the accuracy of the HCFA information through a review of our internal information. We have found only minor problems with the accuracy of the HCFA data and are comfortable that the numbers truly reflect CAMC's mortality experience as defined by HCFA.

There are many indicators of a hospital's performance. Mortality is only one such indicator. The Charleston Area Medical Center has in place a quality assurance program that looks at many other indicators of the quality of care provided at our institution. This is an extensive program of review that monitors the care provided by our physicians, nurses, and other ancillary departments through a program designed to systematically monitor and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. CAMC enjoys a full accreditation status from the Joint Commission on Accreditation of Hospitals as evidence of our committment to providing a high level of quality of care to all of our patients.

City Hospital, Inc.
Dry Run Road P.O. Box 1418
Martinsburg, WV 25401
304-263-8971

PROVIDER NUMBER: 510008 October 27, 1987

COMMENTS REGARDING HCFA MORTALITY DATA

The staff of City Hospital, Inc. upon receiving the summary of the mortality data compiled by HCFA, reviewed the medical records of the patients listed. This review revealed two errors which require correction:

1. [redacted]: Admitted on 12-7-86 and discharged 12-23-86. This patient did not expire on 12-31-86 as recorded and is alive as of this date.
2. [redacted]: Admitted on 5-15-86 and discharged on 5-23-86. This patient expired on 5-23-86, not 5-31-86 as documented.

City Hospital appreciates the intent of the Health Care Financing Administration to provide the public with information regarding the outcome of their hospital experiences. However, the trustees and medical staff of City Hospital wish to go on record as expressing a shared opinion that statistical models such as the one utilized by HCFA in the compilation of this data should not be the sole measurement of "quality of care". City Hospital plans to integrate the HCFA information into its ongoing, interactive quality monitoring system. The HCFA data will be yet another tool used in the evaluation of our progress in achieving optimal healthcare on behalf of those whom we serve.

Peter L. Mulford
Administrator

FAIRMONT GENERAL HOSPITAL, INC.



1325 LOCUST AVENUE
FAIRMONT, WEST VIRGINIA 26554
304/367-7100

November 3, 1987

Mr. Harvey Brook
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
6300 Security Blvd.
2D2 Meadows East Building
Baltimore, MD 21207

RE: Medicare Provider Number 510047

Dear Mr. Brook:

The HCFA mortality information published, details the Medicare mortality rate for 1986 admissions and for mortality occurring within 30 days of discharge from Fairmont General Hospital, Inc.

The data used by HCFA indicates that a total of 239 Medicare patients admitted to Fairmont General Hospital died within 30 days of admission. Of these, 181 died while still a patient at Fairmont General, while 58 died after discharge.

Cerebrovascular accident is the only area where Fairmont General's mortality rate as calculated by HCFA was outside the predicted range established by HCFA. HCFA's statistical model does not take into consideration that patients are admitted to hospitals to die and/or a patient's desire that no extraordinary life sustaining actions be taken. Fairmont General Hospital is located in an area where nursing homes tend to send patients to hospitals to die and Fairmont General Hospital respects patients wishes for no extraordinary efforts to sustain life. In this category, the age range of Medicare patients treated was 65 - 96 with the average age being 81.03 years.

HCFA statistical model also does not include how ill the patient was at the time of admission, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness, the patient's psychological state or patient's general health status. All of these factors are important considerations when determining the possibility of death. Since the HCFA statistical model does not include all factors, we feel it can only act as a guide to illustrate potential areas for closer review. Fairmont General Hospital conducts its own ongoing review of patient care utilizing recognized standards/protocols of the Peer Review Organization and other industry.

We salute HCFA's efforts to look at mortality data nationwide and trust that HCFA's future endeavors will include some of the factors discussed above.

Sincerely,

Robert M. Ptomey
Adminstrator & CEO

RMP:mbs

Gary L. Park
President and Chief Executive Officer

Thomas Memorial Hospital
4605 MacCorkle Avenue, S.W.
South Charleston, West Virginia 25309
304-766-3523

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Doctor Roper:

Re: Hospital ID 510029

We are in receipt of your letter regarding Thomas Memorial Hospital's mortality data as prepared by the Health Care Financing Administration. Although the information regarding Medicare patients identified by HCFA who were admitted and died during 1986 appears to be essentially correct, we have been unable to confirm the accuracy of all the data due to time constraints. We are particularly interested in verifying data regarding patients dying in other settings (i.e. home, nursing home and personal care home).

While we are not particularly dissatisfied with our overall actual mortality rate of 12 percent when compared with a predicted range of 9 to 15 percent, we have great difficulty accepting the premise that such raw mortality data represents a valid assessment of the quality of care rendered in this or any other institution. Quality as related to health care is, of course, very difficult to define and is probably even a more difficult parameter to measure. Any attempt at measuring such quality that does not address the severity of illness of the patients and their socioeconomic and genetic background is flawed and will fall short of the goal. There is tremendous concern on the part of our Medical Staff that HCFA's analysis is not capable of accurately attributing a patient's death to the care provided by the hospital and thus, should not be presented as such.

The relatively few diagnostic categories in which our actual mortality rates exceed the median of your predicted range of rates may indeed be skewed by our patient mix. Our service area includes not only a large segment of elderly persons but unique environmental and work factors peculiar to our region which traditionally results in a high incidence of pneumoconiosis and other pulmonary related diseases.

Many institutions of high repute and perceived by physicians and the public at large as delivering high quality medical care attract a high percentage of extremely ill patients with disease entities having extremely high mortality rates. Raw mortality data in such instances will certainly not reflect the true quality of care provided by these institutions.

We wish to restate that we have serious reservations about mortality rates based on raw data and its relationship to quality care. The value of presenting such information publicly may indeed be premature and misleading in many instances and we question the wisdom of this action.

Sincerely,

Gary L. Park
President

George W. Hogshead, M.D.
Medical Director

GLP/GWH:bh

P.O. Box 497
Ronceverte, WV 24970
Tel. No. (304) 647-4431

Humana Hospital
Greenbrier Valley

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Doctor Roper:

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - Greenbrier Valley supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's Quality Assurance Manager and medical staff have reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

I hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

Sincerely,

Greg L. Gibson
Executive Director

GLG/kmb

Humana Hospital
St. Luke's - Medicare Provider No. - 51-0067

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, DC 20201

Dear Dr. Roper:

Humana Hospital St. Luke's - Bluefield appreciates the opportunity to comment on hospital specific mortality data realizing its significance in public education and quality measurement. We would like to aid the Health Care Financing Administration's attempts to provide not only measurable quality standards to consumers, but also to provide our industry with information pertinent to internal quality assurance monitoring.

We realize that the measurements provided to hospitals are preliminary and understand that more specific quality measures will follow. Therefore, we are concerned that these new mortality figures provide the consumer with only very limited information which is not adjusted for severity of illness or other factors which may affect a patients outcome. The importance of warning consumers must be stressed, and consumers must be cautioned about drawing any final conclusions based upon these figures alone.

For all deaths occurring in our hospital, a complete internal review is undertaken to determine the appropriateness of care rendered, and to aid medical professionals in improving future patient care. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. The extensive quality control systems present in modern hospitals must be brought to the consumer's attention as well as mortality figures indicating perhaps a less than optimal outcome.

Several professionals at our facility, the Director of Medical Records, Director of Quality Assurance, Utilization Review Coordinator and Associate Executive Director have reviewed the data provided to us. Generally, the information is consistent with that in our records. There was one reported death, however, for a patient who was already dead upon arrival in the Emergency Room.

An additional item to be considered is that the percentage of Medicare patients treated at our hospital is greater than those treated at other area hospitals and greater than the state average. Specifically, 45.4% of St. Luke's patients for the last fiscal year were Medicare patients whereas 32% on the average of the local and state competitors' paient mix is Medicare. These individuals are obviously more prone to death and have more contributing complications than younger patients. Despite this fact, the number of deaths in each category fell within the "expected ranges" identified by HCFA.

We regret that the number of cases in each category is too small to provide statistically valid conclusions. In addition, the predicted ranges are too broad to be considered concrete standards for quality measurement. In the future, however, the efforts of HCFA and the health care industry are bound to provide mere statistically valid information to both providers and consumers. We offer our assistance to all involved parties in this important effort.

Sincerely,

Bradly R. Anderson
Executive Director

BA/df

RESPONSE TO HCFA ON HOSPITAL MORTALITY RATES

Thank you for the opportunity to comment on the hospital specific mortality data provided to us late last month. Humana Hospital - _____ supports the Health Care Financing Administration's desire to educate those interested in Medicare quality issues. We recognize this program is early in its development stages. While its measurements are preliminary and rough, it is clearly an example of the type of quality measurements to come.

This information is helpful in our hospital's ongoing quality assurance program that includes regular and complete review of all admissions which result in patient mortality, regular morbidity and mortality reviews, quality assurance, utilization review, as well as complete outside review by the Joint Commission on Accreditation of Health Organizations and other outside review organizations.

Since these raw numbers reflect deaths which occurred in only a limited segment of a hospital's patient population (the elderly) and are not adjusted for severity of illness or other factors which may affect patient outcome, they must be considered in that context and should serve as only one of numerous indicators used to review the quality of services provided at an individual hospital. While this statistical data is useful in this format for professional evaluation, it is not beneficial for consumer use. As a result, consumers should be informed as to the limited scope of these numbers, and be cautioned about drawing any conclusions from the data about the quality of a particular hospital's services.

As in all deaths occurring in hospitals, a complete internal review is necessary to determine the appropriateness of the outcome and may provide information to physicians and other medical providers about improvements which can be made in treating future patients. Thus, the use of raw mortality statistics is helpful to professionals in identifying patient trends and treatment outcomes. Additionally, they may assist health care consumers in understanding the extensive quality control systems in place in hospitals.

Our hospital's (medical records, quality assurance, and/or medical staff) has (have) reviewed the data. Since some deaths occurred outside the hospital, we have been unable to completely validate this data. Generally, we have found it to be consistent [with some (major) exceptions] with our hospital records. Unfortunately, in most cases the number of patients in a particular category is too small to provide a valid statistical analysis. In addition, the predicted ranges are extremely broad and have been developed in such a complex and unverifiable manner, it would be inappropriate to consider them acceptable or unacceptable "standards."

(Specifically, we reviewed all categories and find that under category.....)

I (We) hope this information will be helpful in attempting to refine the collection and reporting of raw hospital data. In addition, our hospital will do everything possible to assist our community in understanding how this data can best be used to improve health care services.

HCA Huntington Hospital

COMMENTS REGARDING MORTALITY STATISTICS
MEDICARE PATIENTS 1986

MEDICARE PROVIDED NUMBER: 510014

Investigation into the sepsis mortality review of HCA Huntington Hospital revealed that six patients were admitted to the hospital in 1986 with the primary diagnosis of sepsis. All six patients had contributory chronic multiple system involvement in addition to sepsis. Two of these patients were aged 90 and 94 respectively. Four patients expired at the hospital and one patient expired within 30 days of discharge (in a nursing home). Retrospective review through the appropriate Medical Staff Committee revealed unanimous and independent agreement that all cases were managed appropriately and that the percentage reflected by these statistics (83% mortality) in no way is an indicator of substandard quality care. In addition, none of the six charts involved were identified by West Virginia Medical Institute, Inc., the regional PRO, as to being deficient in the care provided by either the hospital or the physicians involved.

1230 Sixth Avenue
P.O. Box 1875
Huntington, West Virginia 25719-1875
Telephone (304) 526-9111

Monongalia
General
Hospital
1200
J D Anderson Drive
Morgantown WV
26505
304-598-1212

COMMENTS ON THE HCFA MORTALITY DATA
MONONGALIA GENERAL HOSPITAL
MORGANTOWN, WEST VIRGINIA
PROVIDER #51-0024

The data used by HCFA indicate that 248 of 2,160 Medicare patients admitted to Monongalia General Hospital in 1986 died within thirty days of admission. Our records show that 3,618 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries which were not included in the HCFA sample. We have no way of verifying HCFA's data. Our review confirms that only 194 Medicare patients actually died while in our hospital in 1986. It is impossible for us to determine if the 54 remaining patients died following discharge since information concerning death after discharge is not usually part of the patient's hospital medical record.

While we are pleased our results indicate we are well within the predicted mortality ranges for each category, we view this model only as an attempt to statistically predict the risk of death for certain types of patients and not as a valid measure of the quality of care to be expected from any individual institution.

OVMC Ohio Valley Medical Center, Inc.
Wheeling, West Virginia 26003
304 - 234-0123

51-0039

October 23, 1987

Mr. William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, DC 20201

Dear Dr. Roper:

Having reviewed the mortality data for Medicare patients treated at Ohio Valley Medical Center, including Ohio Valley General Hospital and Peterson Hospital, we note that the actual mortality rates for all diagnostic categories fall within the range of predicted mortality rates for 1986. These data may prove useful to individual hospitals' Quality Assurance programs; however, we caution that there are limitations to the use of this information.

Medical Staff Committees within the Ohio Valley Medical Center are continuing to screen the data. The Medical Center closely monitors quality of care through its long-standing and newly revised Quality Assurance Program. Quality judgments can only be made after reviewing the information on severity of illness and secondary diagnosis contained in individual patients' medical records.

HCFA in the following published quote has made it clear that this information cannot measure the quality of care at an individual hospital: "While we believe that information on hospital mortality rates is useful, until we have developed additional statistical measures to deal with complex issues such as severity of illness, we can not and do not recommend the use of this information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals."

Sincerely,

Thomas P Galinski

Thomas P. Galinski, President
Ohio Valley Health Services and
Education Corporation

PLATEAU MEDICAL CENTER

Your Bridge To Better Health

An American Healthcare Management Facility

October 26, 1987

Mr. William L. Roper, MD, Administrator
HEALTH CARE FINANCING ADMINISTRATION
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Please be advised that Plateau Medical Center has received information relative to the Mortality Statistics for 1986. Our Quality Assurance representatives have reviewed this information, and it has been determined that 108 Medicare patients were admitted to Plateau Medical Center in 1986 that died within thirty (30) days of admission. Of these patients, 93 died while still inpatients and 15 died after discharge. It is not possible to verify date and time of death of discharged patients through medical records as this information is not included in the patient's record.

The average life expectancy of males in West Virginia is 68.8 years and nationally 70.1 years. The average life expectancy for females in West Virginia is 76.9 years and, on a national basis, is 77.6 years. According to your records, at HCFA, the average age of Medicare patients who died at Plateau Medical Center in 1986 was 80 years of age.

In four of the diagnostic categories listed, the hospital's actual mortality rate falls out of the range of the predicted mortality rate. In three of these categories, PMC was above the expected range and in one category it was below the expected range. The following observations were made from a chart review: For patients dying with cancer of whatever cause, as the principal diagnosis, the average age was 75 years. These charts were reviewed and found to have listed numerous complicating factors and co-morbid conditions that indicated extensive disease processes among these people, including metastatic disease. Not taken into consideration in the HCFA study is the fact that terminally ill patients have multiple causes of complications and co-morbid conditions with chemotherapy and radiation having their own associated risks including potentially fatal complications.

430 MAIN STREET — OAK HILL, WEST VIRGINIA 25901 — PHONE 304-465-0551

The average age for patients suffering Severe Acute Heart Disease was 69. All patients in this category were reviewed and found to have experienced an acute onset of myocardial infarction with complicating factors eventually resulting in death.

The average age of patients dying from Urological Disease as the principal diagnosis was 84 years of age. Not taken into account is the fact that these people died not only from the urological problem but from associated systemic infections and multi-system complications related to the infections and other co-morbid conditions.

For patients dying from Low Risk Heart Disease, Plateau Medical Center is below the expected range. In all likelihood, the illnesses which people in this category experienced did not result in death but only extensive illness.

Among the services that Plateau Medical Center offers are those related to long-term outpatient and home care of the chronically and terminally ill. Thus, patients are being kept alive longer outside the hospital and are only admitted when their cause is so severe that all resources as an outpatient are exhausted.

We have verified your data and the Quality Assurance Coordinator, together with the Quality Assurance Committee have reviewed individual cases. They have made two observations; first, no gross problems can be identified; second, further studies and review of individual cases are being contemplated to evaluate the predictability of deaths on a medical basis as well as on the basis of other conditions of hospital care.

PMc was above the predicated mortality range in several areas in which our status and that of the range was so close as to be insignificant. Taking into account the average age of patients at PMC, the amount of outpatient home care provided, and the numbers of co-morbid conditions of our patients, we feel that the quality of care being provided at this facility favorably matches local and national standards.

This data is very helpful in spurring us to look closer at the quality of care at all levels and further studies will be designed and undertaken in the near future.

Sincerely,

Charles E. Kuebler
Administrator

cc: J. Michael Herr, DO, Chairman
Q. A. Committee

Lynn Legg, RN, BSN
Q. A. Coordinator

PLEASANT VALLEY HOSPITAL

Dennis L. Carder
Assistant Executive Director

October 23, 1987

Telephone
(304) 675-4340

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, MD 21207

Dear Sir:

Upon receipt of your mortality information for the year 1986, a request was made by the Medical Staff for a full medical record review of the two (2) categories in which Pleasant Valley Hospital exceeded the range of predicted mortality rates. The outcome of the review, not including comorbid and associated diseases and other pertinent demographic data, indicates a discrepancy in the number of cases utilized in your statistical analysis. For our specific institution we have utilized the DRG validation sheet as submitted to our Medicare PRO within the state of West Virginia as the basis for the number of cases and the number of deaths for each diagnostic category.

Diagnostic Category CE (Stroke or cerebrovascular accident)

	# of Cases	# of Deaths	% of Mortality
HCFA	26	14	54%
PVH	47	14	29.8%

Diagnostic Category HM (Severe chronic heart disease)

	# of Cases	# of Deaths	% of Mortality
HCFA	44	18	41%
PVH	83	18	21.7%

Thank you for the opportunity to review the information prior to publishing. If our calculations are based on disparate data, I would appreciate your reply.

Sincerely,

Dennis L. Carder

Dennis L. Carder
Assistant Executive Director

DLC:dai

ATTACHMENT 4

COMMENTS ON THE HCFA MORTALITY DATA
Memorial Hospital, ~~Middletown~~, ~~Anystate~~

51-0043

Data Verification

The data used by HCFA indicate that a total of 38 Medicare patients admitted to Pocahontas Memorial hospital died within 30 days of admission. Of these, 35 died while still a patient of the hospital, while 3 died after discharge. Our own records indicate that 430 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at Pocahontas Memorial hospital is correct. Our own records also indicate that of the 35 Medicare patients who died within 30 days of admission while still an inpatient, 3 were still alive at the time of discharge. [NOTE: the hospital should submit to HCFA a corrected copy of the patient listing clearly identifying any patients mistakenly coded as dead at the time of discharge.] It is impossible to determine the percentage of the 3 patients dying after discarge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

In None of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. After correcting the errors in the recording of deaths, the number of categories in which the actual mortality rate is outside the range of the predicted mortality rate falls to None. Several factors may account for this difference.

Unique Services Resulting in Higher than Average Mortality.

Results of Prelimary Medicare Record Review.

ATTACHMENT 5

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Deaths Verified by Hospital*	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	4		4	
CE -- Cerebrovascular Accidents	5		5	
GC -- Gastrointestinal Catastrophes	1		1	
GI -- Gastrointestinal Disease	0		0	
GU -- Urologic Disease	1		1	
GY -- Gynecologic Disease	0		0	
HL -- Low Risk Heart Disease	0		0	
HM -- Severe Chronic Heart Disease	6		5	
HS -- Severe Acute Heart Disease	2		2	
ME -- Metabolic/Electrolyte Disturbances	1		1	
OP -- Orthopedic Disorders	0		0	
PN -- Pulmonary Disease	11	3	12	3
RN -- Renal Disease	3		3	
SE -- Sepsis	1		1	
TR -- Severe Trauma	0		0	
OP -- Ophthalmalogic Disease	0		0	
UN -- Other Diagnoses	0		0	
Total -- All Categories	35	3	35	3

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

Our county's population average age is 65 or greater, making Pocahontas County the highest elderly populated county in the state, thereby, deaths by natural causes would be greater, as natural causes in no longer a term utilized on the death certificates, but is now broken down into disease categories. We do not find these Actual Mortality rates unusual.

William Browning, JR D.O.
Chief Of Staff

HCA Putnam General Hospital

October 27, 1987

Health Care Financing Adminsitration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Greetings:

Subject: Hospital Mortality Information
Hospital #510085

We have reviewed the listing of individuals which was forwarded to the hospital under cover of Dr. Roper's September 21, 1987 letter. I am returning an enlarged copy of that form. Any corrections in the last seven columns have been hand-written to the right of the incorrect information. These corrections constitute the only comments I wish to make on behalf of Putnam General Hospital.

Sincerely,

Dennis P. Bridgeman
Administrator

DPB:glt
Enclosure

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

1400 Hospital Drive
Post Office Box 900
Hurricane, West Virginia 25526-0900
Telephone (304) 757-9800
A subsidiary of HCA The Healthcare Company

HCA Raleigh General Hospital

October 23, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

Enclosed is our preliminary response to the Health Care Financing Administration mortality information.

In the coming weeks our review and verification of these cases will continue.

Sincerely,

Kenneth M. Holt
Administrator

KMH/inm
encl.

1710 Harper Road
Beckley, WV 25801-3397
(304) 256-4100
A Subsidiary of HCA The Healthcare Company

COMMENTS ON THE H.C.F.A. MORTALITY DATA
RALEIGH GENERAL HOSPITAL, #510070
BECKLEY, WEST VIRGINIA 25801

Our records indicate that 3,508 medicare patients were admitted to Raleigh General Hospital during 1986. The Health Care Financing Administration shows 2,129. These numbers vary as the H.C.F.A. numbers excludes all but the last admission of beneficiaries admitted more than once during the year.

Interpretative Remarks

In only one of the diagnostic categories, cardiovascular accidents, does the hospital's actual mortality rate fall outside the range of the predicted mortality rate. Raleigh General Hospital was 1% above the predicted rate in this category.

Unique Services Resulting in Higher than Average Mortality

Raleigh General Hospital is a 266-bed acute care hospital serving rural Southern West Virginia. According to the 1980 census, the census for the hospital's primary service area was 180,677, of which 144,591 is considered rural population.

This hospital serves as a referral center for smaller community hospitals and nursing homes in the area. Our hospital provides neurosurgery, oncology, and acute coronary care among its services. Therefore, many of the more acutely ill patients are transferred here for care. Many of the patients admitted here are more acutely ill because of the distance they travel to receive medical care.

Results of Preliminary Medical Record Review

Our initial review has consisted of review of records of patients in CE (cerebrovascular accidents) category as we were 1% above the predicted mortality rate.

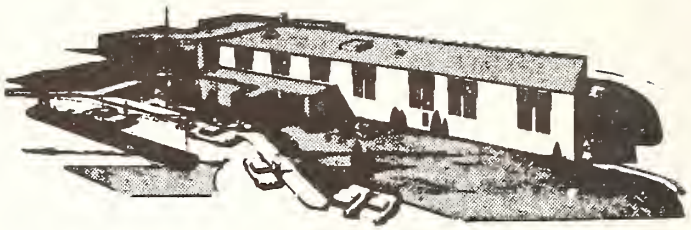
Of the 32 cases treated here, 28 expired here and four expired after being discharged from the hospital. Six patients were transferred from other acute care centers, and three from area nursing homes. Twenty-three were over age 70. Eighteen patients were unresponsive on admission.

Summary

In the coming weeks, a review of in-house and post-discharge mortalities will be conducted.

ROANE
GENERAL
HOSPITAL

200 HOSPITAL DRIVE
SPENCER, WEST VIRGINIA 25276



TELEPHONE 927-4444 • AREA CODE 304

COMMENTS ON THE HCFA MORTALITY DATA

ROANE GENERAL HOSPITAL

Spencer, W.Va. 25276

Provider Number-510081

The data used by HCFA indicate that a total of 69 Medicare patients admitted to Roane General Hospital died within 30 days of admission. Of these 49 died while still a patient of the hospital, while 19 died after discharge. Our records indicate that 56 died while still a patient of the hospital and 12 died after discharge. All deaths have been verified.

Our records also show that 1109 Medicare admissions occurred in 1986 as compared to 563 Medicare admissions indicated on the data used by HCFA. The discrepancy presumably reflects multiple admissions of individual beneficiaries to different hospitals.

Roane General Hospital's actual mortality rate in all diagnostic categories falls within the range of predicted mortality rates. Further comment is not felt necessary based on the information available.

David G. Graham
Administrator
Roane General Hospital

DGG/djn

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.



ST.
JOSEPH'S
HOSPITAL

MEDICARE PROVIDER #: 51-0033

October 16, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for the opportunity to comment on the mortality data. Below I have the comments for publication.

COMMENTS

St. Joseph's Hospital is a general acute care facility of 375 licensed beds serving primarily eight West Virginia and three Ohio counties in the Mid-Ohio Valley Region. Located in Parkersburg, West Virginia, the hospital serves a city that borders the Ohio River and is comprised of large chemical and industrial metal manufacturers. St. Joseph's was established in 1902 and is sponsored by the Sisters of St. Joseph's of Wheeling, West Virginia.

We appreciate the opportunity to review the data prior to the date of release to the public. In reviewing the data we noted seven errors in the patient listing. Five were concerning incorrect dates of admission and discharge. Two patients listed could not be identified as having hospitalizations at St. Joseph's Hospital. Their information, except name, was a duplicate of the patient preceding them on the list, indicating to us that they were most likely in error.

19th Street and Murdoch Ave. Parkersburg, WV 26101 1-304-424-4111

VHA
Partner–VHA Mid-Atlantic
Affiliate of the Voluntary
Hospitals of America System.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

ERRORS

[redacted] Date of death listed as 2/18/86. Date should be 2/17/86

[redacted] Date of death listed as 6/30/86. Date should be 6/28/86.

[redacted] Date of admission listed as 12/09/86. Date should be 12/10/86.

[redacted] Date of death listed as 3/31/86. Date should be 3/1/86.

[redacted] Date of death listed as 11/20/86. Date should be 11/21/86.

Patient information same as preceding patient on list for the following two cases. We cannot locate these patients in our files with the information provided.

[redacted]

St. Joseph's Hospital mortality rates are all in the range of predicted mortality rates, however the hospital wishes to comment on two categories that appear at the higher levels of those ranges. Pulmonary disease rates can be attributed to the location of the hospital in a river valley region in which many industrial manufacturers are located. Renal disease rates can be attributed to the fact that the hospital's renal dialysis unit solely serves an eleven county region and also patients beyond that region.

Very truly yours,

Arthur A. Maher

Arthur A. Maher, President
and Chief Executive Officer

BF/lk/3342L



ST.
JOSEPH'S
HOSPITAL

MEDICARE PROVIDER #: 51-0033

COMMENTS

St. Joseph's Hospital is a general acute care facility of 375 licensed beds serving primarily eight West Virginia and three Ohio counties in the Mid-Ohio Valley Region. Located in Parkersburg, West Virginia, the hospital serves a city that borders the Ohio River and is comprised of large chemical and industrial metal manufacturers. St. Joseph's was established in 1902 and is sponsored by the Sisters of St. Joseph's of Wheeling, West Virginia.

We appreciate the opportunity to review the data prior to the date of release to the public. In reviewing the data we noted seven errors in the patient listing. Five were concerning incorrect dates of admission and discharge. Two patients listed could not be identified as having hospitalizations at St. Joseph's Hospital. Their information, except name, was a duplicate of the patient preceding them on the list, indicating to us that they were most likely in error.

19th Street and Murdoch Ave. Parkersburg, WV 26101 1-304-424-4111

VHA
Partner–VHA Mid-Atlantic
Affiliate of the Voluntary
Hospitals of America System

St. Mary's Hospital
2900 First Avenue / Huntington, West Virginia 25701 / (304) 526-1234
October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, DC 20201

Dear Doctor Roper:

The following is in response to recent correspondence regarding mortality information of Medicare patients that you plan to publish in December.

Raw data such as contained in this report are interesting and useful as an investigational tool and as such it will be incorporated into our Quality Assurance Program that includes, among other entities, mortality review and an ongoing review process that causes the review of all cases that have occurrences outside the course of events that would be customary for hospitalized patients.

While we are very appreciative of your efforts to provide us with information not available to us that you feel would be helpful, we feel it should be noted that 15% of the deaths included in our statistics occurred outside the hospital. Since the report does not contain the cause of death, it is inferred that these patients died from the disease they were treated for in our institution. This is not necessarily a valid conclusion as their deaths may have been from some cause entirely unrelated to their disease process. Hopefully, we will be able to obtain the actual cause of death from county courthouses on those patients who did not die within the confines of our hospital and include this data in our own internal studies.

We plan to use this raw data as the foundation for in depth studies of some of the specific diseases which fall under the broad heading of some of these categories.

Certain conclusions can be immediately drawn from this data even in it's raw state. For an instance, some categories while within the predicted range, are higher than others. In our case, these fall mainly within the categories of cancer and severe heart disease. Our hospital offers cardiac catheterization and open heart surgery as well as Cobalt, Linear Accelerator therapy and other sophisticated cancer treatments. We have thus become a referral center for a geographical region that is marked by a paucity of primary care physicians. By the time some of our patients in these categories seek medical help and are referred to us, it is too late for them to respond to these therapies.

Although you have invited us to validate your report by verifying the data, we have chosen not to respond to this invitation except to say that we have checked very briefly the data on those patients who were listed by you as dying after discharge and have identified a 2% error rate. We do not feel that it would be productive use of time to validate every parameter of your report. However, we would like to address a few brief remarks to your study design.

We feel it would have been most helpful if your statistician had provided us with the exact relationship of each of your weighing factors to the final outcome. We also feel that the study design is weakened by the fact that those Medicare patients who died in the hospital after 30 days are not included and that the cause of death is not one of the variables you used. In addition, any study or set of statistics dealing with mortality rates that is based only on the Medicare population is of necessity already skewed because of the age factor. Our own internal review includes all deaths of all ages and is compared to hospital admissions. Your study does not take into account that in 1986 we had a total of 5,393 Medicare admissions.

In conclusion, it is to be hoped that the general public does not construe your publication to be a gauge of quality. All health care professionals know that mortality review is, as it should be, only a small part of programs developed by all hospitals to try to provide optimal care for their patients. We hope that this effort to inform the consumer does not in reality misdirect them.

Sincerely yours,

Steve J. Soltis,
Executive Director



Stonewall Jackson
MEMORIAL HOSPITAL
TELEPHONE 304—269-3000
WESTON, WEST VIRGINIA 26452

October 16, 1987

COMMENTS ON THE HCFA MORTALITY DATA

Data Verification

The data used by HCFA indicate that a total of 62 Medicare patients admitted to Stonewall Jackson Memorial Hospital died within 30 days of admission. Of these, 48 died while still a patient of the hospital, while 14 died after discharge. Our own records indicate that 1068 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Our records also indicate that of 47 Medicare patients who died within 30 days of admission while still an inpatient, 1021 were stil alive at the time of discharge. It is almost impossible to determine the percentage of the Medicare patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record. However, upon checking the emergency room records of our hospital we could determine that of the 15 patients that died outside of the hospital, 5 were brought into our facility later DOA, 2 patients were brought to the emergency room alive but efforts to treat the patient were to no avail and they died in the emergency room, and 2 patients died at the nursing home where they had been sent upon discharge. The remaining 6 patients date of death were not verified.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

In none of the diagnostic categories did the hospital's actual mortality rate fall outside of the range of the predicted mortality rate.

Unique Services Resulting in Higher than Average Mortality.
Not applicable.

Results of Preliminary Medicare Record Review.
[redacted] Page, Diagnostic Category UN, Date of Admission 6/14/86, Date of Discharge 6/24/86, Date of Death 6/24/86. This patient did not die while an inpatient. The patient had been discharged and was at home at the time of death.

COMMENTS ON THE HCFA
MORTALITY DATA

UNITED HOSPITAL CENTER, CLARKSBURG, WEST VIRGINIA

OCTOBER 28, 1987

I. CHARACTER STATEMENT

United Hospital Center located in Clarksburg, West Virginia is licensed for 396 beds and presently serves patients from a multi-county region of North Central West Virginia, characterized as a rural area with mountainous terrain. A primary service area is composed of approximately 161,000 persons in 6 counties; a contiguous service area of 7 counties has a population of approximately 130,000. Thus nearly 200,000 persons reside in this 13 county area which includes 15 percent of the population who are over the age of 65 years of age.

In addition to the significant elderly/aging population, 59 percent of the service area population are above 200 percent of the poverty level; 15 percent are below 100 percent of the poverty level; 26 percent are between 100 to 199 percent of the poverty level. The Department of Human Services Office estimates that 15 percent are recipients of Medicaid and other public welfare services.

Derived from the 1985 Vital Statistics Report issued from the West Virginia Department of Health, this 13 county region has a higher mortality rate than the entire state of West Virginia and the United States. Specifically, for disease of the heart, the 1985 data (most recent available) shows a rate of 452.6 deaths/100,000 population for the UHC service area compared to a West Virginia rate of 399.4 deaths/100,000 and a national rate of 315 deaths/100,000.

Malignant neoplasms account for a service area rate of 220.3 deaths/100,000 compared to a West Virginia rate of 213.4 deaths/100,000 and a national rate of 191.7 deaths/100,000. Cerebrovascular diseases account for a service area rate of 83.8 deaths/100,000 compared to a West Virginia rate of 70.3 deaths/100,000 and a national rate of 64 deaths/100,000. The service area also has a high rate of COPD and related pulmonary disease due to the influence of coal mining as the primary employment for the region throughout the 1930-50's. The region has an unusually high federally adjusted unemployment rate for the 1980's, ranging from 12 to 18 percent for the various counties included.

II. DATA VERIFICATION AND LIMITATIONS

Results released from HCFA show United Hospital Center actual mortality rates fall within the range of predicted mortality rates in 18 of 19 diagnostic categories. In one category, severe acute heart disease, the hospital's actual mortality rate is only 2% above the predicted mortality rate. The following will address the methodology used by HCFA to obtain mortality rates, verify the data compiled by HCFA and provide in-depth analysis of selected diagnostic categories.

The data used by HCFA indicate that a total of 423 Medicare patients admitted to United Hospital Center died within 30 days of admission. Of these, 339 died while still a patient of the hospital, while 84 died after discharge. Data submitted by HCFA showed 3,251 Medicare admissions in 1986 for United Hospital Center, however UHC records indicate that 5,033 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. There is no way of verifying whether the number of Medicare patients treated at United Hospital Center is correct. United Hospital Center records also indicate that of the 423 Medicare patients who died within 30 days of admission while still an inpatient, 84 were still alive at the time of discharge. It is impossible to determine the percentage of the 84 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the analysis. Moreover, the limitations of mortality information on Medicare patients have surfaced as a result of preliminary medical record review at United Hospital Center. Although it has a statistical basis, the HCFA model fails to take into account a number of factors that contribute to a patient's death. These factors include the following:

First, complicating conditions affecting the patient's principle illness. For example, in cancer of the diagnostic categories, many individuals were admitted with pneumonia, renal failure, chronic obstructive pulmonary disease and arteriosclerotic cardiovascular disease. These conditions or secondary ailments affected the patient's health status and contributed to their death. In review of the diagnostic category of severe acute heart disease, quality assurance analysis reveals that 21 of the 49 patients (43%) had multi system disease defined as principal secondary diagnoses involving more than one organ system. These patients were frequently extremely complicated and had many problems other than the principal cardiac diagnosis with which they were admitted and which certainly contributed to their death in many instances.

Twelve charts were reviewed in the category of renal disease. In many of the cases agressive treatment was discussed with the family but not pursued because of such secondary illnesses as Alzheimer's and Parkinson's disease.

Second, social and economic factors in the UHC service area such as medically indigent/needy families and the unemployed all present demands on the health care system. Many individuals fail to seek adequate medical attention because of financial barriers which lead to untimely admissions. By the time these individuals are admitted to UHC, their disease may be at an acute or terminal stage.

Third, personal health care habits, including but not limited to compliance with physician-recommended diets and medication plans, are not always followed by patients. Complications may intensify or arise when individuals elect to be cared for at home, away from professional

healthcare monitoring. Once again this results in an untimely admission to the hospital.

Fourth, the HCFA report does not take into consideration the fact that the majority of patients coming to United Hospital Center are from the elderly population. The hospital does not service an "average" (according to age) mix of patients. 51 percent of UHC's patient days are utilized by the Medicare population. The average age of the Medicare patient was greater than 70 in 11 of the 16 diagnostic categories used by HCFA, and greater than age 80 in four categories. This age factor is significant because it directly affects the individual's chance of death. In the severe acute heart disease category, 11 of the 50 patients were over the age of 80 years (22%).

Finally, patients that leave the hospital against medical advice or elect not to have any extraordinary measures taken to prolong their life have put themselves at a greater risk of dying. In the severe acute heart disease category, 10 of the patients or 20% were classified as "CMO" meaning that the family and or patient themselves had decided that no aggressive action should be undertaken. In those cases, the wishes of the patient and the family were honored and very little was done to intervene with terminal events during the course of the patients hospitalization. An additional patient left the hospital against medical advice.

Some data may be suspect in certain categories with a small sample size, as the impact of random variations of outcomes in individual cases is greater. This should be noted in the UHC data on renal disease.

Granted, HCFA made some changes in their statistical methods; however, it still creates a misleading picture for identifying quality patient care at United Hospital Center. Determinations on quality of care should not only be based on whether or not a patient died within 30 days of his/her hospital admission, but should also include all other significant factors--including the ones previously mentioned.

III. QUALITY PATIENT CARE MONITORING & EVALUATION

United Hospital Center's Quality Assurance Program provides for ongoing objective and systematic monitoring and evaluation of the quality and appropriateness of patient care, pursuing opportunities to improve patient care, and resolve identified problems. This program is hospitalwide and is supported by the governing body. As part of the hospital's Quality Assurance Program, mortality chart review is done on all deaths within the respective medical staff departments.

The following criteria is used when reviewing death cases: progress notes indicating awareness of the critical nature of the case; physicians orders; consultation ordered; laboratory procedures ordered; supervision of the case and early recognition of complications; re-evaluations of clinical and laboratory studies to check the progress of the case; and modification of the therapeutic regime in accord with the changing condition of the patient. Once the medical staff department has reviewed the chart based on this criteria, if there is a question on any aspect of treatment, clarification from attending physician is requested. The minutes of the department

meeting will reflect this and any actions taken. Mortality chart review is only one of many ongoing quality assurance activities performed to ensure quality patient care in the institution.

Hospital ID Number - 510006

Patient ID Number ((HIC)	Surname (first 6 ltrs)	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death	Principal Diagnosis	Principal Procedure
[redacted]	[redacted]	CA	070	F	02/26/86	03/04/86 discharged from hospital alive	03/04/86	1628	3324
[redacted]	[redacted]	CA	082	M	09/01/86	09/03/86 discharged from hospital alive	09/02/86	20005	
[redacted]	[redacted]	CA	076	M	02/02/86	02/04/86 patient died on this date	02/06/86 patient did not die on this date	1532	
[redacted]	[redacted]	CE	081	M	08/16/86	09/08/86 patient died on this date	09/09/86 patient did not die on this date	436	8703
[redacted]	[redacted]	CE	088	F	10/28/86	11/09/86 patient died on 11/08/86	11/09/86 patient did not die on this date	4349	8703
[redacted]	[redacted]	CE	093	M	04/09/86	04/09/86 patient died on 04/10/86	04/09/86 patient did not die on this date	04/09/86	431
[redacted]	[redacted]	GC	060	M	07/15/86	07/16/86 patient died on this date	07/17/86 patient did not die on this date	570	
[redacted]	[redacted]	GI	082	F	06/24/86	06/24/86 patient died on this date	06/30/86 patient did die on this date		

WV 65.4

Hospital ID Number - 510006

Patient ID Number ((HIC)	Surname (first 6 ltrs)	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death	Principal Diagnosis	Principal Procedure
[redacted]	[redacted]	HM	089	M	08/11/86	08/19/86 patient died on this date	08/18/86 patient did not die on this date	4281	9904
[redacted]	[redacted]	HS	069	F	11/22/86	11/24/86 patient died on this date	11/30/86 patient did not die on this date	4101	
[redacted]	[redacted]	HS	084	F	10/11/86	10/30/86 patient died on this date	10/31/86 patient did not die on this date	4101	
[redacted]	[redacted]	HS	069	F	03/22/86	03/30/86 patient died on this date	03/31/86 patient did not die on date	4104	3771
[redacted]	[redacted]	HS	067	M	10/14/86	11/01/86 patient left A.M.A.	1/01/86	4101	
[redacted]	[redacted]	HS	078	M	12/24/86	12/25/86 patient died on this date	12/31/86 patient did not die on this date	4108	
[redacted]	[redacted]	PN	087	F	02/10/86	02/10/86 patient died on this date	02/28/86 patient did not die on this date	486	
[redacted]	[redacted]	PN	081	F	02/15/86	02/25/86 Patient died on this date	02/26/86 patient did not die on this date	486	
[redacted]	[redacted]	PN	072	M	04/28/86 last adm. was 05/22/86	05/05/86 last disch. was 05/27/86	05/27/86 patient died on this date	486 Principal dx was 4321	8703 No procedure performed

WV 65.5

Hospital ID Number - 510006

Patient ID Number ((HIC)	Surname (first 6 ltrs)	Diagnostic Category	Age	Sex	Date of Admission	Date of Discharge	Date of Death	Principal Diagnosis	Principal Procedure
[redacted]	[redacted]	VN	081	F	03/28/86	04/02/86 pt. died on this date	04/03/86 pt. did not die on this date	44421	3803
[redacted]	[redacted]	VN	078	M	05/02/86 Last adm. was 05/29/86	05/09/86 Last disch. was 05/31/86	05/31/86 Pt. died on this date	2809 Principal dx. was 44422	9904 Principal procedure was 3929

WV 64.6

Weirton Osteopathic Hospital INC.

3045 Pennsylvania Avenue
Weirton, West Virginia 26062-3045
304-723-1200 or 304-723-1201

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Weirton Osteopathic Hospital
Medicare Provider Number 510076

To Whom it May Concern:

Comments Re: Mortality Rate Report 1986 From Weirton Osteopathic Hospital.

1. Headings on your report are confusing, at best. For instance, WOH is a 16 bed family oriented general hospital. That information should make the statistics more meaningful, if placed on the report.

2. You also reported as follows:

CASES	ACTUAL MORTALITY RATE	PREDICTED RANGE
This is actually admissions of that diagnosis not cases of death.	% rate is okay, but actual number would clarify.	Good to know, but high for a 16 bed facility. I doubt the calculation.

Sincerely,

Kitty McFarland

Kitty McFarland, Asst. Administrator

West Virginia University Hospitals, Inc.
Office of the Administrator

October 26, 1987

MEDICARE PROVIDER #: 510001

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health & Human Services
Washington, D.C. 20201

Dear Dr. Roper:

West Virginia University Hospitals, Inc. (WVUH) is pleased to provide comments to HCFA regarding our review of the 1986 Medicare mortality information. WVUH is a 452-bed tertiary referral center which serves the state of West Virginia, southwestern Pennsylvania, northwestern Maryland, and eastern Ohio. We are a large acute care hospital with teaching programs in numerous medical specialties and subspecialties.

WVUH and its medical staff place a high value on the quality of care we provide to Medicare and to all patients. We are committed to provide state-of-the-art acute and specialized healthcare services to our service area, to serve as a center for medical research and advancement, and to provide clinical education to graduate and undergraduate students in medicine and other health sciences. In addition, we play a critical role in this region's healthcare delivery system as a regional referral center for complex, highly sophisticated tertiary care that is generally unavailable in community hospitals. We have specialized programs in kidney transplantation and renal dialysis, orthopedic and neurosurgery, neonatal intensive care, and open heart surgery which are highly recognized, and our oncology program is recognized by the Commission on Cancer as a designated Cancer Center. In addition, the Jon Michael Moore Trauma Center is designated as the state's only Level I Trauma program. In a rural state such as West Virginia, these services are not readily available throughout the state.

THE HCFA MODEL

While we appreciate HCFA's stated goal of measuring hospital performance, we do not believe that this mortality study, or any simple statistical approach, categorically accomplishes this goal, because not all valid patient characteristics are included in this model. For example:

1. The Medicare model does not incorporate several patient characteristics which we believe are significant predictors of mortality. Chief among these is the lack of severity of illness as an indicator. For example, while two patients with a diagnosis of congestive heart failure may both be treated in the hospital, one patient may have multiple organ involvement, and require more intensive care, while a less complex patient will have a better prognosis. In addition, valid indicators such as socio-economic factors, transfers from nursing homes, psychological status, and general health state are also not included in the model.

2. The model does not address the special capabilities of hospitals such as WVUH which provide highly specialized services not available from providers which do not have the facilities or expertise to provide additional care. Therefore,

hospitals providing specialized care not offered elsewhere are apt to be the final place of treatment for a patient. These patients are counted only in the final hospital's mortality rates. Due to transfers from other hospitals and patient/family knowledge of the availability of such services, tertiary referral centers receive the more critically ill patients, which adversely affects our statistics. For example, WVUH's current Medicare case-mix index (a gross measure of resource intensity) is 1.35 meaning that our patients are roughly 35% more resource intensive than the average Medicare patient and thus require more specialized services.

3. An appropriate assessment of hospital performance is dependent upon many variables and requires analysis of many quality indicators of which mortality is but one. The Joint Commission on Accreditation of Hospitals and the American Hospital Association have been investigating methods of evaluating hospital quality that rely on measures other than mortality rates, and we look forward to the results of these efforts as well as other multi-dimensional approaches to quality measurement.

4. The model does not incorporate regional patterns of care which have a direct bearing on mortality rates. Admissions from nursing homes of patients with chronic degenerative conditions where demise is imminent is an example of patterns not accounted for in the model.

5. For those variables the model does incorporate, the HCFA data on WVUH include incorrect and incomplete information on some of our patients. Our corrected data are being forwarded to HCFA to improve the accuracy of the reported information. For example, in some cases the autopsy findings will pinpoint different underlying causes of death than that information obtained by HCFA at discharge.

THE WVUH DATA

West Virginia University Hospitals, Inc. has reviewed the medical records of patients included on our 1986 mortality list. Our overall mortality rate of Medicare patients who died in the hospital or within 30 days of discharge was 14% in 1986. Due to the short time period to respond to HCFA (one month), we focused our initial efforts to verify the data and develop interpretive comments for those diagnostic categories in which the actual mortality rate is outside the range of the predicted mortality rate. Of the seventeen diagnostic categories, there are four we wish to comment on. However, the comments we have provided could apply equally to the thirteen diagnostic categories where our actual mortality rate was within the predicted range.

High Risk Severe Chronic Heart Disease
HCFA Predicted Range: 16 - 35%
Actual Mortality Rate: 38%

The majority of these patients were admitted due to congestive heart failure. The average patient was 74.6 years, and 79% of these patients had had prior hospitalizations. We do not believe that the HCFA model fully addressed the combination of age and prior medical history in predicting the mortality rate. Of those patients that expired in the hospital, two-thirds had exhausted reasonable life-supporting and life-sustaining measures. For these patients, a decision had been made by the family and/or physician prior to the patient's demise that no extraordinary measures should be carried out to prolong the patient's life.

High Risk Stroke
HCFA Predicted Range: 17 - 43%
Actual Mortality Rate: 44%

This category includes high risk stroke patients with diagnosis of cerebrovascular accidents and cerebrovascular hemorrhages. The average age of these patients was 74.3 years. This category illustrates the referral nature of our hospital, as 55% of these patients were transferred in from other hospitals and nursing homes. Of those patients that expired in the hospital, 73% had exhausted reasonable life-supporting and life-sustaining measures prior to their deaths. Again, a decision had been made prior to the patient's demise that no extraordinary measures should be carried out to prolong the patient's life.

Septicemia - High Risk
HCFA Predicted Range: 16 - 64%
Actual Mortality Rate: 71%

Again, the average age of these patients was 80.0 years, and 50% of these patients were transferred to WVUH from other hospitals and nursing homes. Forty percent of these patient had complications and comorbidities which are not accounted for in HCFA's analysis, and these data are included for HCFA review and incorporation into the model. Fifty percent of these patients had been evaluated as having a severe physiologically compromised status which combined with the average age of 80.0 presented less than a good prognosis on admission. Age is an important factor in the recovery from septicemia, the physical debilitation of the patient is of very high significance when considering outcome. Considering the low number of cases in this category, there is question of statistical reliability.

Low Risk Heart Disease
HCFA Predicted Range: 3 - 10%
Actual Mortality Rate: 11%

We believe that this diagnostic category is clearly a misnomer in that 42% of these patients required some form of heart and/or vascular surgery. In most cases where either of these forms of surgical intervention are coupled with a low risk heart diagnoses, there is a positive correlation with the patient's severity of illness. This correlation holds true despite the fact that the patients with surgical intervention were an average age of 69.3, while the average medical patient was 75 years old.

In conclusion, we support the continued refinement of the HCFA and other mortality data. We will be engaged in a hospital-wide effort to continue the review of this study and provide any additional feedback to HCFA on how to improve its mortality studies.

Sincerely,

Bernard Westfall
President

MEDICAL PARK · WHEELING, WEST VIRGINIA 26003 (304) 243-3000
SKILL, SERVICE, HOPE AND LOVE

WHEELING HOSPITAL

MEDICARE PROVIDER #510050

Wheeling Hospital is a 276-bed, non-profit hospital. The hospital serves as a regional medical facility and offers primary, secondary, and tertiary care services. The hospital has a medical staff of 225 physicians in all medical specialties. As a regional referral center for care, Wheeling Hospital receives substantial numbers of acutely-ill patients.

Although the mortality rates for all disease categories at Wheeling Hospital fall within the predicted Medicare mortality rates, Wheeling Hospital notes the following:

1. The records indicate twenty-seven percent (27%) of the Medicare reported deaths for Wheeling Hospital did not occur while an inpatient at Wheeling Hospital. It is impossible to determine if information relating to these deaths, which would have occurred after discharge, is correct. Information concerning death after discharge is not in the patient's medical record.

2. Deaths in Wheeling Hospital's service area from heart disease (461 deaths per 100,000 persons) is significantly higher than the State of West Virginia (406 deaths per 100,000 persons) and the United States (324 deaths per 100,000 persons). This higher death rate may be caused in part by environmental factors and/or the lack of angioplasty and open-heart surgery services in the area.

3. Mortality is only one measure of the quality of care. Other factors including clinical severity of patients, technical competence of staff physicians as represented by training and board certification, currency of technology and the level of activity (number of procedures performed) are considered in evaluating quality of care at Wheeling Hosptial. An active peer review process, such as Wheeling Hospital conducts, also involves evaluation of morbidity factors, such as nosocomial infection rates, patient education, discharge planning, and follow-up care which impact on the quality of care provided. And lastly, but not least, Wheeling Hospital measures patient satisfaction which provides evaluation of care from the perspective of the patient as well as their families. The quality of care at Wheeling Hosptial speaks for itself by the wide acceptance of our facility by the community.

WYOMING GENERAL HOSPITAL

P. O. Box 847
Mullens, West Virginia 25882

October 15, 1987 MEDICARE PROVIDER # 510054

[redacted]: Transferred fro WGH to Wyoming Continuous Care Nursing Home as a terminal cancer patient.

[redacted] Patient had been at Charleston Area Medical Center. He was a terminal cancer patient. Patient's family preferred that he be treated at the WGH. Patient's family preferred no code.

[redacted] 74 years old. Acute myocardial infarction with congestive heart failure.

[redacted] Patient had an acute myocardial infarction.

[redacted]. Have no information where this patient expired.

[redacted] Patient with a CVA. Severe heart disease, blind, severe diabetic, paralysis. She was 52 years old.

[redacted]: Young man in 40's had a myocardial infarction. He was air lifted to Charleston. He refused further medical procedures and he expired.

[redacted]: This patient had had multiple admissions. She was a total bed patient in the home. Her condition had deteriorated considerably and she expired. Pulmonary disease.

[redacted]: Have no information where this patient expired. He had had a CVA and myocardial infarction, age undetermined.

[redacted]: Terminal cancer patient, metastatic to liver and stomach.

[redacted] Have no information where this patient expired.

[redacted] This patient had congestive failure with pleural effusion complicated by pneumonia.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Wisconsin

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																							
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
A CENTER OF RACINE INC RACINE WI 53404	WI-13 *	25	0	0-26	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
ADAMS COUNTY MEMORIAL HOSP FRIENDSHIP WI 53934	WI-14 *	340	11	7-16	21	19	8-44	13	54	11-59	10	0	1-49	9	22	7-60	12	25	16-67	9	11	4-56	26	8	9-42
ALGOMA MEMORIAL HOSPITAL ALGOMA WI 54201	WI-15 *	150	14	9-22	7	29	8-70	4	50	5-79	2	50	0-93	18	22	7-44	16	31	20-66	5	20	4-72	9	11	5-57
APPLE RIVER VALLEY MEM HOS AMERY WI 54001	WI-16 *	308	12	10-19	14	14	10-55	22	27	14-52	9	22	3-54	24	13	11-45	11	45	16-69	10	10	4-53	37	16	11-38
APPLETON MEMORIAL HOSPITAL APPLETON WI 54911	WI-17 *	1460	9	8-15	118	23	13-32	20	10	10-47	32	25	13-44	100	19	15-32	64	22	24-49	12	17	8-57	88	20	13-31
BALOWIN COMMUNITY MEMORIAL BALDWIN WI 54002	WI-18 *	303	12	10-20	12	33	7-54	11	27	12-63	4	0	2-75	9	11	7-60	22	32	24-64	7	0	0-61	30	20	12-44
BARRON MEMORIAL MEDICAL CE BARRON WI 54812	WI-19	472	11	11-20	31	32	15-48	16	38	14-58	11	27	6-54	32	13	11-40	19	26	22-64	25	16	9-43	56	11	12-35
BAY AREA MEDICAL CENTER MA MARINETTE WI 54143	WI-20 *	781	15	9-17	28	36	14-48	36	33	15-45	24	17	6-38	56	25	14-37	36	47	25-57	24	8	4-37	72	25	10-30
BAYFIELD COUNTY MEMORIAL H WASHBURN WI 54891	WI-21 *	129	11	9-22	6	17	10-76	5	40	9-79	2	50	0-90	10	10	7-59	6	17	13-80	3	33	2-82	16	25	6-45
BEAVER DAM COMMUNITY HOSPS BEAVER DAM WI 53916	WI-22 *	983	12	9-16	78	22	11-32	32	22	17-49	28	14	6-36	68	24	14-34	40	35	24-54	15	7	8-51	93	22	13-31
BELLIN MEMORIAL HOSPITAL GREEN BAY WI 54301	WI-23 *	1738	10	7-14	127	15	13-31	58	34	17-41	28	29	8-39	77	14	12-31	86	26	26-48	13	8	3-46	81	22	11-30
BELOIT MEMORIAL HOSPITAL I BELOIT WI 53511	WI-24	1514	14	9-16	82	37	19-41	42	29	17-45	45	20	10-35	87	22	15-33	63	59	28-53	28	18	6-37	141	20	14-29
BERLIN MEMORIAL HOSPITAL BERLIN WI 54923	WI-25 *	751	10	8-15	39	23	11-39	29	31	15-48	14	36	6-50	38	21	13-41	18	28	17-59	27	33	8-41	54	19	10-33
BLACK RIVER FALLS MEM HOSP BLACK RIVER FALLS WI 54615	WI-26	385	14	9-18	21	33	8-45	9	44	7-61	9	11	2-53	20	20	9-46	17	41	17-61	10	10	3-52	57	18	13-36
BLOOMER COMMUNITY MEMORIAL BLOOMER WI 54724	WI-27 *	221	12	9-20	12	8	8-56	9	22	7-60	3	0	0-84	16	31	6-46	9	67	15-72	14	21	7-51	23	9	13-49
BUFFALO MEMORIAL HOSPITAL MONDOVI WI 54755	WI-28 *	116	22	12-27	1	100	1-97	1	100	0-97	5	20	1-69	2	0	1-89	15	33	21-68	5	20	2-69	25	28	11-45
BURNETT GENERAL HOSPITAL I GRANTSBURG WI 54840	WI-29 *	205	18	9-20	8	38	9-67	4	25	5-79	4	75	5-80	14	14	6-49	7	43	12-74	7	57	11-74	23	39	10-44
CALUMET MEMORIAL HOSPITAL CHILTON WI 53014	WI-30	387	15	10-19	21	48	15-55	24	38	15-51	19	11	6-43	19	37	9-47	15	40	21-68	13	0	5-49	26	27	11-44
CHIPPEWA VALLEY HOSP DURAND WI 54736	WI-31 *	230	13	11-22	9	44	14-71	10	20	8-60	7	57	4-63	9	11	8-62	10	40	19-75	3	0	0-84	36	17	15-44
CLINTONVILLE COMMUNITY HOS CLINTONVILLE WI 54929	WI-32 *	249	14	11-22	21	24	12-51	12	50	12-61	7	0	2-59	17	29	9-48	15	33	18-65	7	29	4-62	32	25	14-46
COLUMBIA HOSPITAL MILWAUKEE WI 53211	WI-33	2971	10	8-15	305	22	16-31	118	20	19-37	64	19	12-34	88	26	13-31	89	31	28-50	44	18	9-36	197	19	14-28
COLUMBUS COMMUNITY HOSPITA COLUMBUS WI 53925	WI-34 *	498	10	10-18	26	27	14-49	11	27	14-67	12	17	5-51	31	13	11-40	22	36	21-60	11	9	3-49	69	13	14-35
COMMUNITY MEMORIAL HOSP MENOMONEE FALLS WI 53051	WI-35	1268	10	8-15	100	27	15-35	50	38	17-42	27	7	9-41	66	18	13-34	45	33	26-55	26	8	7-40	81	17	13-32
COMMUNITY MEMORIAL HOSPITA OCONTO FALLS WI 54154	WI-36 *	401	9	9-18	9	44	6-59	12	33	14-64	9	0	3-55	38	24	12-39	14	14	18-66	22	9	4-38	58	12	10-32
COMMUNITY MEMORIAL HOSPITA SPOONER WI 54801	WI-37 *	330	9	9-18	10	20	6-57	15	33	11-55	14	7	2-42	26	15	12-45	7	29	10-72	5	20	1-69	49	12	10-33
CUMBERLAND MEMORIAL HOSPIT CUMBERLAND WI 54829	WI-38 *	336	9	8-17	20	45	12-51	16	31	13-57	13	8	2-43	18	11	10-49	12	42	14-64	10	0	4-55	33	9	8-36

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
A CENTER OF RACINE INC RACINE WI 53404	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
ADAMS COUNTY MEMORIAL HOSP FRIENDSHIP WI 53934	2	50	1-90	1	0	1-97	7	14	0-58	1	0	0-100	39	5	1-19	13	0	1-40	4	0	0-100	17	0	0-33	13	0	0-66
ALGOMA MEMORIAL HOSPITAL ALGOMA WI 54201	1	100	0-99	1	0	0-98	1	0	0-98	.	.		17	0	0-32	2	0	0-90	.	.		11	9	0-48	5	0	.
APPLE RIVER VALLEY MEM HOS AMERY WI 54001	1	0	0-99	1	0	0-97	1	0	0-100	.	.		48	8	2-18	10	10	1-47	4	0	0-100	31	6	1-21	9	0	0-62
APPLETON MEMORIAL HOSPITAL APPLETON WI 54911	10	20	11-67	5	20	9-79	20	10	2-32	6	0	0-100	156	2	2-10	38	0	0-20	16	0	0-93	302	3	3-8	110	1	0-7
BALDWIN COMMUNITY MEMORIAL BALOWIN WI 54002	9	11	10-69	8	25	16-77	9	22	2-51	.	.		37	5	1-20	14	14	0-45	2	0	0-100	27	4	1-23	16	0	0-61
BARRON MEMORIAL MEDICAL CE BARRON WI 54812	2	0	2-90	6	0	12-79	15	7	2-39	.	.		51	0	2-18	14	0	0-39	2	0	0-100	19	5	1-29	29	10	0-21
BAY AREA MEDICAL CENTER MA MARINETTE WI 54143	6	50	7-74	10	20	9-63	32	13	3-25	1	0	0-100	77	8	1-13	33	21	2-23	7	0	0-100	65	6	2-14	56	5	0-12
BAYFIELD COUNTY MEMORIAL H WASHBURN WI 54891	2	50	5-93	.	.		.	.		1	0	0-100	8	0	0-54	1	0	0-100	.	.		6	0	0-67	7	0	0-97
BEAVER DAM COMMUNITY HOSPS BEAVER DAM WI 53916	7	29	4-65	8	13	11-71	34	15	2-23	3	0	0-100	124	6	2-11	58	5	1-16	8	0	0-100	43	5	1-17	63	0	0-11
BELLIN MEMORIAL HOSPITAL GREEN BAY WI 54301	17	29	12-58	6	33	10-77	35	11	2-24	2	0	0-100	139	4	2-11	71	3	1-14	9	0	0-100	331	5	3-8	197	1	0-5
BELOIT MEMORIAL HOSPITAL I BELOIT WI 53511	11	18	3-55	27	48	20-58	41	5	4-24	6	0	0-100	186	8	3-10	44	5	1-18	12	0	0-100	114	4	2-11	104	1	1-8
BERLIN MEMORIAL HOSPITAL BERLIN WI 54923	4	25	3-77	10	40	15-70	35	3	3-24	.	.		84	4	2-12	49	6	2-18	5	0	0-100	58	3	1-15	70	0	0-10
BLACK RIVER FALLS MEM HOSP BLACK RIVER FALLS WI 54615	5	40	1-71	12	17	9-59	.	.		.	.		61	3	2-15	16	6	1-35	2	0	0-100	20	10	1-28	16	0	0-48
BLOOMER COMMUNITY MEMORIAL BLOOMER WI 54724	3	33	2-82	.	.		4	0	0-75	.	.		32	9	1-21	7	0	0-66	1	0	0-100	15	7	0-36	6	0	0-92
BUFFALO MEMORIAL HOSPITAL MONDOVI WI 54755	3	33	2-82	5	60	9-80	.	.		.	.		5	0	0-75	3	33	0-91	1	0	0-100	15	13	1-36	.	.	
BURNETT GENERAL HOSPITAL I GRANTSBURG WI 54840	1	100	0-97	.	.		1	100	1-97	1	0	0-100	17	0	0-34	14	29	2-40	4	0	0-100	24	4	1-25	12	0	0-43
CALUMET MEMORIAL HOSPITAL CHILTON WI 53014	7	14	4-66	2	50	4-92	9	33	2-51	.	.		48	13	2-18	26	4	1-25	4	0	0-100	15	7	1-35	21	0	0-36
CHIPPEWA VALLEY HOSP OURANO WI 54736	1	0	3-99	4	0	5-79	6	17	1-62	1	0	0-100	39	5	2-20	4	0	0-83	1	0	0-100	20	5	1-29	9	11	0-77
CLINTONVILLE COMMUNITY HOS CLINTONVILLE WI 54929	2	0	5-94	1	0	0-97	1	0	0-100	.	.		33	3	1-20	15	0	2-38	1	0	0-100	18	11	1-31	9	0	0-76
COLUMBIA HOSPITAL MILWAUKEE WI 53211	16	13	5-50	34	26	22-57	90	9	4-18	6	0	0-100	289	5	3-9	116	10	2-13	22	0	0-52	147	3	2-10	398	1	0-4
COLUMBUS COMMUNITY HOSPITA COLUMBUS WI 53925	2	0	0-93	12	8	12-63	9	11	1-50	.	.		42	2	1-18	31	13	2-24	9	11	0-78	38	8	2-20	24	0	0-25
COMMUNITY MEMORIAL HOSP MENOMONEE FALLS WI 53051	5	40	8-80	10	30	17-73	40	5	4-26	5	0	0-100	160	3	2-9	83	0	0-14	19	0	0-86	69	4	2-14	105	2	0-8
COMMUNITY MEMORIAL HOSPITA OCONTO FALLS WI 54154	2	0	1-90	7	29	14-77	11	18	3-47	.	.		58	5	2-15	8	0	1-53	5	0	0-100	23	0	1-26	22	0	0-35
COMMUNITY MEMORIAL HOSPITA SPOONER WI 54801	8	50	12-73	7	29	11-74	2	50	1-89	1	0	0-100	38	3	1-18	11	0	0-46	3	0	0-100	26	0	1-24	15	0	0-58
CUMBERLAND MEMORIAL HOSPIT CUMBERLAND WI 54829	.	.		2	50	3-91	2	0	0-95	.	.		39	0	1-18	8	0	0-82	5	0	0-100	30	3	1-23	19	0	0-38

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
DIVINE SAVIOR HOSPITAL PORTAGE WI 53901	WI-39 *	635	15	11-19	51	41	19-46	33	39	17-49	19	11	9-47	41	12	12-39	18	39	18-61	16	13	6-47	78	19	14-34						
DOOR COUNTY MEMORIAL HOSPI STURGEON BAY WI 54235	WI-40 *	620	10	9-17	32	19	9-40	19	42	17-58	21	19	5-39	65	8	14-35	25	52	26-63	10	20	2-51	53	13	11-34						
EAGLE RIVER MEMORIAL HOSPI EAGLE RIVER WI 54521	WI-41 *	240	18	9-20	12	50	11-61	12	42	13-63	6	50	5-68	14	21	8-51	8	0	13-73	6	0	2-64	25	32	11-45						
ELMBROOK MEMORIAL HOSPITAL BROOKFIELD WI 53005	WI-42	1016	11	9-16	81	20	15-37	49	31	17-43	29	21	6-36	48	23	13-37	27	37	23-60	21	24	8-45	68	22	11-32						
FAMILY HOSPITAL MILWAUKEE WI 53208	WI-43 *	920	16	10-17	59	17	12-36	32	25	14-45	27	22	8-39	53	38	14-37	22	68	25-65	31	19	8-39	97	30	15-33						
FIRST HOSPITAL MILWAUKEE MILWAUKEE WI 53208	WI-44 *	7	29	0-63	.	.		.	.		.	.		.	.		.	.		.	.		.	.						
FLAMBEAU MEDICAL CENTER PARK FALLS WI 54552	WI-45 *	347	16	10-19	21	38	11-49	14	36	11-56	11	18	3-49	29	17	9-39	14	50	15-62	3	0	1-81	53	17	12-36						
FORT ATKINSON MEMORIAL HOS FORT ATKINSON WI 53538	WI-46	1073	12	8-16	82	23	13-34	47	40	17-43	20	10	5-41	64	16	14-35	35	31	25-57	35	37	11-42	76	21	12-31						
FREDERIC MUNICIPAL HOSP AS FREDERIC WI 54837	WI-47 *	163	12	8-21	4	50	5-79	6	17	8-73	4	25	2-75	17	24	11-52	6	67	10-76	7	0	3-62	28	7	7-37						
FROEOTERT MEMORIAL LUTHERA MILWAUKEE WI 53226	WI-48	1180	10	8-15	104	13	20-40	50	38	16-42	36	17	13-43	19	11	9-46	3	67	7-88	21	10	5-40	65	25	13-34						
GOOD SAMARITAN MED CTR LUT MILWAUKEE WI 53233	WI-49 *	2054	10	8-15	167	22	16-33	61	21	18-42	46	22	9-33	106	19	14-31	48	31	25-53	41	12	7-34	120	22	17-34						
HARTFORD MEMORIAL HOSPITAL HARTFORD WI 53027	WI-50 *	519	10	10-18	35	26	15-47	17	24	12-54	12	8	7-54	47	11	13-37	12	33	15-66	13	0	5-50	50	18	13-37						
HAYWARD AREA MEM HOSPITAL HAYWARD WI 54843	WI-51	269	10	9-19	10	40	14-69	7	14	7-67	12	17	5-50	8	38	5-61	14	43	17-64	4	0	8-84	37	5	10-37						
HESS MEMORIAL HOSPITAL MAUSTON WI 53948	WI-52 *	434	9	9-18	12	50	6-53	19	11	13-53	8	38	6-62	26	8	11-43	20	20	21-62	20	5	4-39	44	14	11-37						
HOLY CROSS HOSPITAL MERRILL WI 54452	WI-53	505	10	9-17	38	21	12-41	14	36	11-57	16	13	5-44	24	8	12-46	22	32	22-62	9	11	1-53	37	19	12-40						
HOLY FAMILY HOSPITAL MANITOWOC WI 54220	WI-54 *	1138	12	10-17	69	33	18-42	42	33	16-43	20	25	10-49	60	25	15-38	33	45	21-54	30	10	8-40	85	19	13-32						
HOLY FAMILY HOSPITAL NEW RICHMOND WI 54017	WI-55 *	265	14	7-16	9	33	10-66	9	33	9-65	6	33	2-63	6	17	5-68	4	50	7-81	6	0	0-65	25	20	6-36						
HOWARD YOUNG MEDICAL CENTE WOODRUFF WI 54568	WI-56 *	1058	10	8-16	79	27	16-38	27	26	13-47	38	24	11-39	45	20	13-38	38	42	26-57	11	18	3-51	76	13	12-32						
HUDSON MEMORIAL HOSPITAL I HUDSON WI 54016	WI-57	289	21	9-19	32	81	20-53	7	71	9-70	1	0	0-99	16	38	11-53	6	17	6-71	6	33	9-75	21	24	8-43						
INDIANHEAD MEDICAL CENTER SHELL LAKE WI 54871	WI-58 *	247	14	9-19	13	31	12-60	14	14	12-57	8	25	3-57	13	0	6-50	10	60	19-74	8	25	2-56	29	24	8-37						
IOLA HOSPITAL IOLA WI 54945	WI-59 *	77	14	8-25	1	0	0-97	3	67	3-83	1	0	0-98	6	17	4-66	2	50	5-94	6	0	2-65	17	12	8-48						
KAUKAUNA COMMUNITY HOSPITA KAUKAUNA WI 54130	WI-60	285	14	7-17	20	35	11-50	10	50	8-60	16	31	5-44	11	45	7-55	11	27	16-69	13	8	2-45	26	8	5-34						
KENOSHA MEMORIAL HOSPITAL KENOSHA WI 53140	WI-61	1295	10	9-16	73	15	18-42	47	17	15-41	39	18	8-35	96	16	14-31	57	46	27-53	46	22	9-36	103	16	10-27						
LA CROSSE LUTHERAN HOSPITA LA CROSSE WI 54601	WI-62	3621	10	8-14	315	16	15-30	107	35	19-37	80	16	10-30	131	24	17-33	128	35	30-49	71	18	14-37	162	22	16-31						
LAKE MEMORIAL HOSPITAL OSCEOLA WI 54020	WI-63 *	194	11	11-23	13	31	14-63	25	16	14-48	5	20	3-70	11	27	10-60	5	20	9-79	5	20	2-69	19	26	11-50						
LAKELAND HOSPITAL ELKHORN WI 53121	WI-64	1236	13	8-15	94	31	13-33	46	26	17-44	45	29	12-38	70	17	13-33	34	29	21-53	26	27	7-40	102	19	12-30						

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
DIVINE SAVIOR HOSPITAL PORTAGE WI 53901	11	36	7-60	7	43	10-73	18	17	3-36	1	0	0-100	72	6	1-13	29	7	1-24	8	0	0-100	35	3	1-19	37	3	0-17
DOOR COUNTY MEMORIAL HOSPI STURGEON BAY WI 54235	7	29	4-66	1	0	0-97	19	5	3-36	.	.		82	1	2-13	29	0	1-24	4	0	0-100	70	0	1-12	30	0	0-24
EAGLE RIVER MEMORIAL HOSPI EAGLE RIVER WI 54521	2	50	6-94	1	0	1-97	6	17	0-65	.	.		27	4	1-24	15	7	1-37	1	0	0-100	17	0	0-32	12	8	0-53
ELMBROOK MEMORIAL HOSPITAL BROOKFIELD WI 53005	7	14	6-68	8	50	12-72	37	3	2-22	3	0	0-100	107	2	2-12	55	2	1-17	10	0	0-100	58	5	2-15	79	3	0-10
FAMILY HOSPITAL MILWAUKEE WI 53208	6	50	8-75	23	30	20-60	16	13	2-37	.	.		87	8	2-14	42	7	1-20	3	0	0-100	34	18	1-21	35	9	0-19
FIRST HOSPITAL MILWAUKEE MILWAUKEE WI 53208	2	50	0-93	.	.		.	.		.	.		.	.		.	.		.	.		1	0	0-100	1	0	0-100
FLAMBEAU MEDICAL CENTER PARK FALLS WI 54552	8	38	6-66	2	50	9-97	4	25	0-76	.	.		37	5	2-22	8	38	1-53	6	0	0-100	26	4	1-23	8	0	0-92
FORT ATKINSON MEMORIAL HOS FORT ATKINSON WI 53538	3	33	1-82	12	25	14-65	45	4	3-21	12	0	0-99	130	2	2-10	33	3	1-22	17	0	0-96	63	5	2-14	103	2	0-8
FREDERIC MUNICIPAL HOSP AS FREDERIC WI 54837	3	0	1-82	.	.		.	.		.	.		16	0	0-37	9	11	0-58	.	.		20	0	1-28	8	0	0-87
FREDERT MEMORIAL LUTHERA MILWAUKEE WI 53226	67	18	6-35	6	83	13-80	8	50	0-54	1	0	0-100	76	7	4-17	74	5	1-15	6	0	0-100	18	11	1-31	54	2	0-14
GOOD SAMARITAN MED CTR LUT MILWAUKEE WI 53233	19	21	9-52	22	50	15-55	52	15	4-23	37	0	0-43	202	7	3-10	80	3	2-15	12	0	0-98	218	6	2-8	150	2	0-6
HARTFORD MEMORIAL HOSPITAL HARTFORD WI 53027	4	25	6-81	6	50	12-78	11	9	1-44	3	0	0-100	49	10	2-18	21	5	0-30	3	0	0-100	37	3	1-18	33	0	0-20
HAYWARD AREA MEM HOSPITAL HAYWARD WI 54843	4	25	4-79	6	0	8-74	2	0	0-93	.	.		34	3	1-20	5	20	0-72	3	0	0-100	24	8	1-25	13	0	0-78
HESS MEMORIAL HOSPITAL MAUSTON WI 53948	4	75	14-90	13	23	16-66	8	0	1-54	.	.		53	0	1-16	17	0	0-41	6	0	0-100	25	4	0-24	16	0	0-55
HOLY CROSS HOSPITAL MERRILL WI 54452	6	33	9-76	4	0	11-86	2	50	0-99	.	.		58	2	1-15	22	18	1-28	12	0	0-93	42	2	2-18	28	4	0-23
HOLY FAMILY HOSPITAL MANITOWOC WI 54220	11	45	13-67	28	32	20-57	32	3	3-27	6	0	0-98	125	6	3-13	45	0	1-19	11	9	0-100	71	1	2-15	79	0	0-9
HOLY FAMILY HOSPITAL NEW RICHMOND WI 54017	2	0	5-93	1	0	1-97	10	20	1-47	.	.		32	0	1-21	8	0	0-62	4	0	0-100	19	0	0-29	18	0	0-50
HOWARD YOUNG MEDICAL CENTE WOODRUFF WI 54568	9	11	4-60	10	20	16-72	23	13	2-30	2	0	0-100	138	4	3-12	46	0	1-18	20	0	0-96	64	6	2-15	110	1	0-7
HUDSON MEMORIAL HOSPITAL I HUDSON WI 54016	1	100	1-97	.	.		6	50	0-63	.	.		40	8	1-19	14	7	1-38	2	0	0-100	18	0	1-31	28	4	0-26
INDIANHEAD MEDICAL CENTER SHELL LAKE WI 54871	1	100	0-97	.	.		3	0	0-90	.	.		29	14	2-25	11	18	0-54	4	0	0-75	20	0	1-29	12	0	0-76
IOLA HOSPITAL IOLA WI 54945	.	.		.	.		3	0	1-81	.	.		3	0	0-97	.	.		.	.		7	14	0-60	1	0	0-100
KAUKAUNA COMMUNITY HOSPITA KAUKAUNA WI 54130	5	40	5-74	2	100	3-92	11	9	1-44	.	.		42	5	1-17	10	0	0-75	4	0	0-100	17	6	0-33	9	11	0-77
KENOSHA MEMORIAL HOSPITAL KENOSHA WI 53140	11	18	6-59	10	10	12-67	41	10	3-23	1	0	0-100	128	9	3-13	57	4	1-16	8	0	0-100	112	1	2-11	79	3	0-9
LA CROSSE LUTHERAN HOSPITA LA CROSSE WI 54601	29	24	10-48	41	29	22-54	113	8	4-16	49	0	0-26	310	4	2-8	138	1	1-11	38	0	0-60	385	6	2-7	323	1	0-4
LADD MEMORIAL HOSPITAL OSCEOLA WI 54020	3	33	4-86	1	0	2-99	10	0	2-49	.	.		13	8	2-41	8	0	0-66	1	0	0-100	13	8	0-39	9	0	0-88
LAKELAND HOSPITAL ELKHORN WI 53121	8	25	5-64	14	43	14-62	38	8	3-24	5	0	0-100	171	8	2-10	53	0	1-16	8	0	0-100	114	3	2-11	53	6	0-13

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LAKEVIEW HOSPITAL MILWAUKEE WI 53226	WI-65	505	9	6-14	28	14	9-41	10	0	11-64	8	0	2-56	13	38	8-53	13	69	20-69	7	14	4-63	33	21	9-37
LAKEVIEW MEDICAL CENTER RICE LAKE WI 54868	WI-66 *	753	9	8-15	35	20	11-41	19	32	13-53	13	8	3-45	44	23	13-39	27	33	22-59	23	30	11-47	53	15	11-34
LANGLADE COUNTY MEMDRIAL H ANTIGO WI 54409	WI-67 *	641	11	10-18	47	38	16-43	28	25	14-47	20	10	9-47	44	16	13-39	30	40	24-59	12	25	5-51	50	12	13-38
LUTHER HOSPITAL EAU CLAIRE WI 54701	WI-68 *	1654	13	10-16	171	29	20-37	41	41	17-45	29	3	7-37	89	27	15-33	80	43	29-51	30	10	7-38	135	27	14-30
MADISON GENERAL HOSPITAL MADISON WI 53715	WI-69 *	2272	8	7-14	188	16	15-32	70	23	19-42	45	20	8-32	72	21	14-34	77	39	31-54	33	0	9-39	114	16	11-28
MEMORIAL COMMUNITY HDSPITA EDGERTON WI 53534	WI-70 *	343	13	8-18	27	22	9-42	14	50	12-58	15	7	4-43	16	6	6-46	15	33	16-61	13	8	5-49	35	23	10-37
MEMORIAL HOSPITAL LANCASTER WI 53813	WI-71	377	11	8-17	22	32	11-48	14	21	12-58	10	0	3-52	18	39	9-47	10	40	18-73	17	12	8-50	29	17	9-40
MEMORIAL HOSPITAL MANITOWOC WI 54220	WI-72 *	727	10	8-15	40	10	12-40	20	45	11-49	13	23	3-46	40	30	13-40	17	41	19-63	19	21	7-45	61	16	11-32
MEMORIAL HOSPITAL ASSOCIAT BURLINGTON WI 53105	WI-73	810	15	9-16	53	40	10-35	41	29	17-45	27	7	6-37	47	19	11-34	29	31	23-58	24	17	6-40	89	24	13-31
MEMORIAL HOSPITAL AT OCONO OCONOMOWOC WI 53066	WI-74	903	14	9-16	72	24	17-40	39	41	17-46	23	30	6-39	37	14	11-38	35	37	24-56	12	42	6-53	82	24	15-35
MEMORIAL HOSPITAL INC NEILLSVILLE WI 54456	WI-75	346	18	10-19	17	29	8-49	10	10	9-61	17	18	6-45	24	50	11-45	12	50	18-69	10	20	3-52	55	25	13-37
MEMORIAL HOSPITAL OF BDSCO BOSCOBEL WI 53805	WI-76 *	288	17	9-19	9	11	2-53	10	30	11-65	8	25	6-62	21	57	10-47	11	45	15-68	9	0	3-55	38	32	10-37
MEMORIAL HOSPITAL OF IOWA DODGEVILLE WI 53533	WI-77	301	13	10-19	13	38	11-58	10	10	10-63	10	10	3-51	16	13	7-47	15	47	19-65	9	11	2-54	24	17	9-43
MEMDRIAL HOSPITAL DF LAFAY DARLINGTON WI 53530	WI-78 8	247	13	8-18	10	30	6-56	11	55	10-61	7	29	3-60	13	23	10-56	9	56	20-77	6	0	4-68	20	5	6-41
MEMDRIAL HDSPITAL DF TAYLO MEDFORD WI 54451	WI-79	375	10	9-18	24	17	10-45	18	33	12-53	7	0	8-69	19	11	8-45	16	31	20-65	7	29	3-61	39	18	11-38
MEMDRIAL MED ALCOHDL DRUG ASHLAND WI 54806	WI-80 8	17	0	0-38	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
MEMDRIAL MEDICAL CENTER IN ASHLAND WI 54806	WI-81 *	1183	11	8-15	93	18	12-32	35	26	16-45	52	13	6-28	46	15	14-39	59	47	27-53	21	14	8-44	87	20	12-31
MERCY HOSPITAL OF JANESVIL JANESVILLE WI 53545	WI-82	1792	10	8-15	146	21	16-34	67	30	17-39	37	14	7-34	76	21	13-33	69	30	28-52	30	13	6-36	116	22	12-29
MERCY MEDICAL CENTER OSHKOSH WI 54901	WI-83	2197	10	10-16	147	27	19-38	96	23	21-40	55	16	10-34	120	16	17-34	70	40	29-53	37	5	8-37	179	17	15-30
METHDDIST HOSPITAL MADISON WI 53703	WI-84 *	1586	9	7-14	134	13	14-32	43	21	15-41	29	21	7-37	69	22	14-34	48	35	26-54	28	18	7-38	93	20	11-28
MILWAUKEE COUNTY MEDICAL C WAUWAUTOSA WI 53226	WI-85	1536	11	7-13	96	32	20-41	3	67	3-83	22	14	4-37	73	16	13-33	88	52	27-48	16	19	3-42	70	29	12-33
MILWAUKEE PSYCH HDSP WAUWATDSA WI 53213	WI-86 *	21	0	0-32	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
MT SINAI MEDICAL CTR MILWAUKEE WI 53201	WI-87	2434	13	10-16	200	30	20-37	66	32	17-40	45	27	9-34	145	19	16-30	91	26	28-50	54	22	11-36	198	25	15-29
MYRTLE WERTH MEDICAL CENTE MENOMDNIE WI 54751	WI-88 *	553	10	9-17	23	17	9-45	18	6	14-55	17	6	3-39	39	21	13-41	41	39	25-55	25	0	6-39	44	23	9-34
NEW BERLIN MEMDRIAL HDSPIT NEW BERLIN WI 53151	WI-89	409	12	8-17	24	17	9-43	13	38	11-59	9	0	1-52	17	29	9-49	11	27	20-74	16	25	9-51	31	32	10-40
NEW LONDON COMMUNITY HDSPI NEW LONDON WI 54961	WI-90 8	393	10	11-21	30	20	12-45	23	30	18-56	11	27	4-52	28	21	11-43	14	29	22-70	19	11	11-51	36	14	10-38

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LAKEVIEW HOSPITAL MILWAUKEE WI 53226	4	50	1-76	7	57	11-74	10	10	2-48	4	0	0-100	67	6	1-13	20	0	0-30	8	0	0-100	22	5	1-27	102	0	0-8
LAKEVIEW MEDICAL CENTER RICE LAKE WI 54868	4	25	2-76	10	40	11-66	36	6	3-25	4	0	0-100	74	0	1-13	40	0	1-19	14	0	0-96	52	4	1-15	86	1	0-9
LANGLADE COUNTY MEMORIAL H ANTIGO WI 54409	9	11	6-62	13	8	12-61	15	0	2-39	.	.		76	4	1-13	35	3	1-22	14	0	0-98	59	3	1-14	11	0	0-50
LUTHER HOSPITAL EAU CLAIRE WI 54701	11	27	9-63	22	45	25-66	51	6	3-21	1	0	0-100	153	5	2-10	57	4	1-16	18	6	0-42	115	5	2-11	163	1	0-6
MADISON GENERAL HOSPITAL MADISON WI 53715	5	40	4-74	14	14	9-55	89	7	4-17	76	0	0-17	215	3	2-9	102	4	1-12	27	0	0-81	106	6	2-11	240	3	0-5
MEMORIAL COMMUNITY HOSPITA EDGERTON WI 53534	4	25	3-77	6	50	11-78	10	10	1-47	.	.		40	0	1-17	17	0	1-33	1	0	0-100	21	14	1-28	35	0	0-28
MEMORIAL HOSPITAL LANCASTER WI 53813	7	43	2-63	.	.		12	8	1-43	1	0	0-100	70	4	2-14	10	0	0-50	2	0	0-100	24	4	1-25	34	3	0-21
MEMORIAL HOSPITAL MANITOWOC WI 54220	5	40	8-79	13	54	21-72	12	0	1-42	.	.		78	4	2-13	50	2	1-17	6	0	0-100	32	6	1-20	111	0	0-7
MEMORIAL HOSPITAL ASSOCIAT BURLINGTON WI 53105	8	75	5-64	8	25	9-69	30	13	3-28	3	0	0-100	99	5	1-11	30	3	0-23	8	0	0-99	59	8	1-14	47	4	0-15
MEMORIAL HOSPITAL AT OCONO OCONOMOWOC WI 53066	4	0	3-78	11	18	14-67	37	19	3-24	3	0	0-100	97	8	2-12	41	0	0-19	6	0	0-100	60	3	1-14	91	1	0-8
MEMORIAL HOSPITAL INC NEILLSVILLE WI 54456	2	50	1-90	5	20	6-76	5	20	0-70	.	.		49	10	1-16	16	6	1-35	1	0	0-100	35	3	1-19	15	0	0-58
MEMORIAL HOSPITAL OF BOSCO BOSCOBEL WI 53805	3	100	11-93	2	0	4-92	4	0	0-75	.	.		43	5	1-18	8	0	0-60	5	0	0-100	22	9	1-27	13	0	0-53
MEMORIAL HOSPITAL OF IOWA DODGEVILLE WI 53533	6	50	7-74	5	40	14-85	11	18	1-44	.	.		37	5	1-20	14	0	0-40	2	0	0-100	25	4	1-24	11	0	0-76
MEMORIAL HOSPITAL OF LAFAY DARLINGTON WI 53530	1	0	0-100	3	0	11-92	5	0	0-71	.	.		20	0	0-29	12	0	0-44	3	0	0-100	13	0	0-40	11	0	0-65
MEMORIAL HOSPITAL OF TAYLO MEDFORD WI 54451	5	40	5-74	2	0	3-91	4	0	0-79	.			47	2	2-18	22	0	0-29	6	0	0-100	51	0	2-16	12	8	0-64
MEMORIAL MED ALCOHOL DRUG ASHLAND WI 54806	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
MEMORIAL MEDICAL CENTER IN ASHLAND WI 54806	7	57	15-80	4	25	9-84	40	8	3-23	3	0	0-100	105	3	2-12	140	1	1-11	11	0	0-95	68	3	2-14	71	6	0-10
MERCY HOSPITAL OF JANESVIL JANESVILLE WI 53545	14	43	14-65	16	31	12-56	61	5	3-18	12	8	0-98	202	6	2-9	83	0	1-14	16	0	0-88	92	4	2-12	205	0	0-5
MERCY MEDICAL CENTER OSHKOSH WI 54901	17	35	10-55	23	39	24-65	75	7	5-21	12	0	0-96	248	6	3-10	94	3	1-13	25	0	0-84	112	2	2-11	190	1	0-5
METHODIST HOSPITAL MADISON WI 53703	23	22	8-48	5	0	5-74	59	7	3-19	5	0	0-100	131	7	2-11	113	1	1-12	23	0	0-95	224	5	3-9	127	1	0-7
MILWAUKEE COUNTY MEDICAL C WAUWAUTOSA WI 53226	4	50	6-82	9	56	16-74	28	14	2-27	254	0	0-3	61	10	2-15	13	8	2-41	12	0	0-99	200	5	3-10	80	0	0-10
MILWAUKEE PSYCH HOSP WAUWATOSA WI 53213	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
MT SINAI MEDICAL CTR MILWAUKEE WI 53201	18	28	6-49	39	54	20-53	50	14	4-22	9	11	0-80	173	5	3-11	129	5	2-13	12	0	0-93	352	5	3-8	87	3	0-9
MYRTLE WERTH MEDICAL CENTE MENOMONIE WI 54751	4	75	2-77	3	0	4-85	24	0	2-28	.	.		53	8	1-15	20	0	0-31	6	0	0-100	45	4	1-16	51	0	0-14
NEW BERLIN MEMORIAL HOSPIT NEW BERLIN WI 53151	5	20	3-72	7	43	10-73	12	8	1-42	.	.		48	2	1-17	30	10	2-25	1	0	0-100	14	7	1-37	59	0	0-12
NEW LONDON COMMUNITY HOSPI NEW LONDON WI 54961	3	0	10-92	6	50	14-81	14	0	2-40	.	.		42	0	1-17	16	6	0-40	2	0	0-100	24	0	1-26	19	0	0-39

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																							
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
NORTHWEST GENERAL HOSPITAL MILWAUKEE WI 53216	WI-91	358	14	7-16	9	67	5-59	10	30	10-63	11	45	4-51	24	33	11-46	3	0	6-87	4	75	8-84	28	18	6-36
NORTHWOODS HOSPITAL PHELPS WI 54554	WI-92	117	6	9-23	8	13	6-63	5	0	3-70	6	0	3-66	12	8	10-58	5	40	11-81	3	0	0-82	13	8	7-51
OCONTO MEMORIAL HOSPITAL I OCONTO WI 54153	WI-93 *	160	18	10-23	9	44	8-63	7	29	9-70	1	0	0-99	10	30	10-62	6	17	10-75	.	.		21	52	15-54
OSSEO AREA MUNICIPAL HOSPI OSSEO WI 54758	WI-94 *	201	13	8-19	8	38	7-65	10	50	10-63	7	0	2-60	14	29	8-51	11	55	16-69	4	0	1-74	12	8	3-46
PLYMOUTH HOSPITAL INC PLYMOUTH WI 53073	WI-95	292	16	9-19	13	15	12-60	12	67	12-61	7	14	4-63	16	44	9-51	13	38	21-71	14	21	3-44	23	30	10-45
PRAIRIE OU CHIEN MEMORIAL PRAIRIE OU CHIEN WI 53821	WI-96 *	489	14	11-19	24	42	13-49	23	13	14-51	17	24	5-43	32	34	13-43	22	45	29-69	10	10	6-57	85	19	13-33
REEOSBURG MEMORIAL HOSPITA REEOSBURG WI 53959	WI-97	396	14	9-18	21	24	11-49	22	27	16-54	16	19	6-46	22	23	11-46	11	55	15-67	12	25	3-49	39	21	10-37
RICHLAND HOSPITAL RICHLAND CENTER WI 53581	WI-98 *	451	12	10-19	25	40	11-46	25	32	15-50	18	17	6-44	29	17	13-44	19	42	18-59	20	5	8-46	57	16	13-35
RIPON MEMORIAL HOSPITAL IN RIPON WI 54971	WI-99 *	365	12	10-19	24	25	9-43	9	11	11-66	4	0	1-74	30	20	10-40	17	53	23-68	5	0	1-68	58	17	13-36
RIVER FALLS AREA HOSP RIVER FALLS WI 54022	WI-100*	250	16	10-20	13	46	11-58	16	44	12-54	13	8	3-46	16	38	9-50	11	27	17-70	2	50	2-90	21	10	7-42
RIVERSIOE COMM MEM HOSP WAUPACA WI 54981	WI-101*	716	19	11-18	42	29	15-44	24	29	14-49	20	40	9-46	46	35	12-36	22	45	21-61	18	28	7-46	126	30	15-31
RIVERVIEW HOSPITAL WISCONSIN RAPIOS WI 54494	WI-102	754	14	10-18	50	22	13-38	34	38	20-51	21	19	7-42	60	18	12-33	46	39	26-55	15	7	3-44	53	21	13-36
RUSK CO MEM HOSP LADYSMITH WI 54848	WI-103*	376	11	9-18	21	29	12-51	11	27	10-60	7	14	2-59	18	17	8-47	22	45	23-62	9	22	2-53	30	13	9-39
SACREO HEART HOSP OF TOMAH TOMAHAWK WI 54487	WI-104	217	17	10-21	14	43	11-58	14	21	11-57	3	67	1-81	11	27	6-54	9	67	15-72	4	25	1-74	30	17	8-37
SACREO HEART HOSPITAL EAU CLAIRE WI 54701	WI-105*	2137	9	8-14	164	29	19-37	79	28	17-37	25	16	10-44	69	20	16-37	60	23	28-53	40	10	7-33	152	17	13-27
SAUK PRAIRIE MEMORIAL HOSP PRAIRIE OU SAC WI 53578	WI-106	433	7	6-15	29	28	9-40	15	20	11-55	10	20	4-53	13	0	6-49	11	18	14-66	2	50	0-90	36	14	8-35
SHAWANO COMMUNITY HOSPITAL SHAWANO WI 54166	WI-107	691	13	8-16	56	23	12-36	28	43	15-49	11	18	3-49	43	21	12-38	29	45	24-60	15	27	7-49	61	13	9-30
SHEBOYGAN MEMORIAL HOSPITA SHEBOYGAN WI 53081	WI-108	1187	12	8-15	93	24	12-32	44	34	16-43	29	34	8-38	53	21	13-37	32	50	26-60	16	25	7-48	92	20	13-32
SOUTHWEST HEALTH CENTER PLATTEVILLE WI 53818	WI-109	273	17	13-24	11	45	16-70	20	30	15-55	7	29	2-59	22	14	12-48	15	53	20-67	6	0	1-64	49	27	16-42
ST AGNES HOSPITAL FONO OU LAC WI 54935	WI-110	1834	13	9-16	188	24	17-34	57	30	19-43	42	31	11-37	102	28	16-34	66	47	27-52	24	25	9-44	118	19	14-31
ST ANTHONY HOSPITAL MILWAUKEE WI 53233	WI-111*	270	11	5-14	9	11	5-58	7	14	5-64	4	50	5-79	10	30	5-55	3	0	2-82	10	40	4-53	21	29	8-43
ST CATHERINES HOSPITAL KENOSHA WI 53140	WI-112*	1165	13	9-16	73	26	15-37	46	24	17-43	43	12	8-33	85	28	14-33	34	59	24-57	27	26	7-40	85	21	11-30
ST CLARE HOSPITAL BARABOO WI 53913	WI-113*	698	11	8-16	43	19	13-41	22	18	9-45	9	33	2-53	42	19	13-39	20	30	18-58	17	12	6-45	74	23	14-35
ST CLARE HOSPITAL MONROE WI 53566	WI-114*	1316	11	8-15	125	21	16-35	43	30	16-44	27	11	4-34	52	23	13-37	47	38	25-53	22	14	5-39	90	24	12-31
ST CROIX VALLEY MEMORIAL H SAINT CROIX FALLS WI 54024	WI-115*	451	10	10-19	21	24	12-50	14	57	15-62	7	0	2-59	24	25	12-46	25	24	23-60	14	7	8-53	49	14	13-38
ST CROIX VALLEY MEN HOSP/A SAINT CROIX FALLS WI 54024	WI-116	7	0	0-62	.	.		.	.		.	.		.	.		.	.		.	.		.	.	

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
NORTHWEST GENERAL HOSPITAL MILWAUKEE WI 53216	3	67	6-88	9	44	20-79	4	25	1-73	.	.		39	10	2-20	7	0	1-58	3	0	0-100	28	4	1-22	43	2	0-16
NORTHWOODS HOSPITAL PHELPS WI 54554	1	0	0-99	2	0	4-92	1	0	0-100	.	.		14	0	0-40	1	0	0-97	.	.		12	0	0-42	3	0	0-98
OCONTO MEMORIAL HOSPITAL I OCONTO WI 54153	2	50	6-94	3	0	5-86	6	0	1-62	.	.		16	13	2-37	2	0	0-96	.	.		13	8	0-40	12	0	0-68
OSSEO AREA MUNICIPAL HOSPI OSSEO WI 54758	3	33	3-84	3	33	8-89	1	0	0-100	.	.		23	4	1-26	4	0	0-83	2	0	0-100	25	4	1-24	18	6	0-34
PLYMOUTH HOSPITAL INC PLYMOUTH WI 53073	2	50	2-91	2	0	3-92	7	14	1-57	.	.		41	10	2-20	14	7	0-41	6	0	0-100	17	0	1-32	9	0	0-65
PRAIRIE OU CHIEN MEMORIAL PRAIRIE DU CHIEN WI 53821	6	17	3-68	4	25	8-83	9	0	0-50	.			49	6	1-16	23	0	1-27	5	0	0-100	43	5	1-18	20	5	0-32
REEDSBURG MEMORIAL HOSPITA REEDSBURG WI 53959	1	0	0-99	6	67	12-79	10	20	1-47	1	0	0-100	46	4	1-17	14	7	0-40	4	0	0-100	28	0	1-23	23	0	0-35
RICHLAND HOSPITAL RICHLAND CENTER WI 53581	3	33	1-82	8	25	13-74	17	18	2-35	1	0	0-100	43	2	1-18	25	0	0-29	3	0	0-100	16	13	0-34	27	0	0-24
RIPON MEMORIAL HOSPITAL IN RIPON WI 54971	2	50	5-94	4	75	7-83	12	8	2-43	.	.		55	4	1-15	14	0	0-40	2	0	0-100	22	5	1-27	22	0	0-31
RIVER FALLS AREA HOSP RIVER FALLS WI 54022	6	17	7-74	3	67	7-88	12	25	3-46	.	.		24	0	1-25	4	0	0-96	1	0	0-100	14	7	0-37	14	0	0-73
RIVERSIDE COMM MEM HOSP WAUPACA WI 54981	6	50	2-67	7	0	12-75	38	11	2-22	3	0	0-100	68	10	3-16	41	5	1-19	2	0	0-100	57	5	2-15	39	3	0-17
RIVERVIEW HOSPITAL WISCONSIN RAPIDS WI 54494	9	33	5-61	9	11	13-70	35	11	5-29	2	0	0-100	79	4	1-13	43	0	0-20	7	0	0-96	49	6	2-17	54	0	0-13
RUSK CO MEM HOSP LADYSMITH WI 54848	5	20	6-77	.	.		.	.		1	0	0-100	55	5	2-17	15	0	1-36	5	0	0-100	26	8	1-24	13	0	0-46
SACRED HEART HOSP OF TOMAH TOMAHAWK WI 54487	3	0	1-82	3	33	5-86	1	100	0-99	.	.		27	4	1-23	7	14	0-62	.	.		21	5	1-27	4	0	0-78
SACRED HEART HOSPITAL EAU CLAIRE WI 54701	7	14	3-64	17	24	19-65	71	7	3-18	45	2	0-32	188	5	2-9	81	7	1-14	21	0	0-88	124	1	2-11	225	3	0-5
SAUK PRAIRIE MEMORIAL HOSP PRAIRIE DU SAC WI 53578	2	0	3-91	7	14	10-73	19	11	2-34	.	.		42	0	1-18	13	0	0-42	2	0	0-100	30	3	1-22	64	2	0-12
SHAWANO COMMUNITY HOSPITAL SHAWANO WI 54166	5	20	7-78	6	50	9-76	33	9	2-24	.	.		95	6	2-12	47	2	1-18	8	0	0-99	31	0	1-20	32	3	0-23
SHEBOYGAN MEMORIAL HOSPITA SHEBOYGAN WI 53081	3	0	2-82	7	29	11-74	33	3	2-23	2	0	0-100	140	6	2-11	67	3	1-15	12	0	0-79	35	6	1-20	65	3	0-11
SOUTHWEST HEALTH CENTER PLATTEVILLE WI 53818	6	33	4-69	6	33	11-78	6	17	1-62	.	.		23	4	0-26	3	0	0-99	1	0	0-100	14	0	1-37	13	0	0-79
ST AGNES HOSPITAL FOND DU LAC WI 54935	5	20	12-84	6	33	12-79	78	5	4-18	7	0	0-96	229	5	3-10	84	2	1-14	18	0	0-94	118	6	2-11	126	1	1-7
ST ANTHONY HOSPITAL MILWAUKEE WI 53233	1	100	1-97	4	50	7-83	6	17	1-62	.	.		13	8	1-39	10	30	1-47	.	.		19	0	0-31	42	0	0-24
ST CATHERINES HOSPITAL KENOSHA WI 53140	15	27	6-52	11	36	15-69	28	14	4-31	4	0	0-100	102	6	2-13	67	4	2-16	9	0	0-100	73	7	2-13	67	3	0-11
ST CLARE HOSPITAL BARABOO WI 53913	3	67	2-82	6	17	8-73	27	4	2-27	.	.		83	8	2-13	37	5	2-22	6	0	0-100	36	3	1-18	61	2	0-12
ST CLARE HOSPITAL MONROE WI 53566	11	9	6-58	16	56	17-63	25	8	2-28	11	0	0-100	189	7	2-10	63	5	0-16	12	0	0-99	40	0	1-17	161	1	0-6
ST CROIX VALLEY MEMORIAL H SAINT CROIX FALLS WI 54024	7	43	12-76	8	25	10-69	3	0	0-88	1	0	0-100	62	5	2-16	24	4	1-27	5	0	0-100	39	0	1-18	15	0	0-39
ST CROIX VALLEY MEM HOSP/A SAINT CROIX FALLS WI 54024	.	.		.	.		.	.		.			.	.		.	.		.			.			.	.	

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
ST ELIZABETH HOSP APPLETON WI 54911	WI-117	1661	11	9-15	166	26	18-36	41	34	17-45	33	15	8-37	76	17	15-35	45	44	26-55	26	15	10-45	107	17	13-30						
ST FRANCIS HOSPITAL MILWAUKEE WI 53215	WI-118	2162	11	9-15	134	21	16-34	76	17	18-39	36	14	8-35	151	25	16-31	69	36	27-51	70	19	7-29	117	20	13-30						
ST FRANCIS MEDICAL CENTER LA CROSSE WI 54601	WI-119	2073	12	9-16	167	25	15-32	93	37	20-40	52	17	9-32	85	29	15-33	86	29	28-50	47	21	12-39	144	15	15-30						
ST JOSEPH HOSPITAL ARCADIA WI 54612	WI-120	96	13	9-25	5	40	4-71	10	20	12-66	3	33	1-81	3	0	3-83	4	25	11-86	7	29	4-63	7	14	3-60						
ST JOSEPH'S HOSPITAL CHIPPEWA FALLS WI 54729	WI-121	954	12	10-17	61	21	17-42	30	27	15-47	18	17	9-49	68	26	15-36	23	17	23-62	24	13	10-46	111	24	14-31						
ST JOSEPH'S HOSPITAL CHIPPEWA FALLS WI 54729	WI-122*	18	0	0-35	.	.		.	.		.	.		.	.		.	.		.	.		.	.							
ST JOSEPHS COMMUNITY HOSPI WEST BEND WI 53095	WI-123	827	10	9-16	83	20	14-35	28	18	15-49	15	20	7-49	59	22	12-34	31	39	26-60	13	23	3-46	48	10	12-36						
ST JOSEPHS HOSP MARSHFIELD WI 54449	WI-124	3864	10	9-16	462	21	20-34	81	32	18-39	79	23	11-31	143	19	16-30	151	30	29-47	50	16	12-38	213	18	15-28						
ST JOSEPHS HOSP MILWAUKEE WI 53210	WI-125	4178	13	10-16	399	33	20-34	135	31	22-39	95	26	12-31	215	21	18-30	190	34	33-50	79	11	8-29	265	20	18-31						
ST JOSEPHS MEMORIAL HOSP HILLSBORO WI 54634	WI-126	252	15	8-18	18	50	11-52	14	21	12-57	8	0	2-55	22	32	10-45	5	40	7-76	5	20	1-69	26	19	10-42						
ST LUKES HOSPITAL MILWAUKEE WI 53215	WI-127	5230	11	9-15	295	22	19-34	141	26	20-36	66	24	12-35	291	20	17-28	227	40	31-46	93	28	13-34	282	24	16-28						
ST LUKES HOSPITAL RACINE WI 53403	WI-128*	1178	14	9-16	105	37	17-37	27	15	14-48	25	4	6-38	57	26	14-36	35	49	26-58	31	6	8-38	64	23	12-33						
ST MARY'S HOSPITAL OZAUKEE PORT WASHINGTON WI 53078	WI-129	593	12	8-16	62	34	15-39	27	7	12-44	6	0	1-63	32	28	13-43	12	75	19-71	12	17	3-47	57	23	10-31						
ST MARYS HOSP MILWAUKEE WI 53211	WI-130	2014	13	9-15	216	43	20-37	64	28	20-43	44	14	9-34	85	11	14-32	52	38	26-54	35	17	8-37	118	21	11-28						
ST MARYS HOSP SPARTA WI 54656	WI-131*	311	12	10-20	12	33	6-53	14	14	10-55	11	9	4-52	21	24	8-42	23	35	23-62	13	0	4-48	34	12	9-37						
ST MARYS HOSPITAL RHINELANDER WI 54501	WI-132	1043	12	8-15	69	39	13-35	43	33	15-42	36	22	9-37	49	18	11-34	40	28	22-53	13	15	3-47	93	17	13-31						
ST MARYS HOSPITAL MED CTR GREEN BAY WI 54303	WI-133*	1418	9	8-15	103	21	13-33	39	28	16-44	37	8	5-30	114	20	16-33	52	38	27-54	17	24	7-47	118	8	11-27						
ST MARYS HOSPITAL MEDICAL MADISON WI 53715	WI-134	3257	10	8-15	304	21	18-33	121	26	19-36	49	8	6-29	143	15	16-31	109	29	28-48	66	14	10-33	187	16	14-28						
ST MARYS KEWAUNEE AREA MEM KEWAUNEE WI 54216	WI-135*	158	18	13-27	12	42	8-56	6	33	4-67	6	33	5-69	10	30	9-61	13	15	21-70	8	50	9-67	24	33	14-49						
ST MARYS MEDICAL CTR RACINE WI 53405	WI-136*	2301	13	9-16	184	18	13-29	107	34	19-37	53	23	9-33	149	26	17-31	99	37	30-51	47	21	10-36	172	17	13-27						
ST MICHAEL HOSPITAL MILWAUKEE WI 53209	WI-137	2591	12	10-16	171	25	18-35	105	31	20-38	55	22	7-30	172	22	17-31	89	40	29-51	63	24	14-38	192	21	17-31						
ST MICHAELS HOSP STEVENS POINT WI 54481	WI-138*	1134	12	9-17	74	20	15-37	38	37	16-46	26	31	10-44	72	25	17-38	45	42	25-54	18	6	4-41	99	15	13-31						
ST NICHOLAS HOSP SHEBOYGAN WI 53081	WI-139	1468	15	9-16	122	24	13-31	62	35	17-39	44	25	12-39	84	38	17-36	67	45	27-51	36	19	8-36	121	27	12-28						
ST VINCENT HOSPITAL GREEN BAY WI 54301	WI-140	2870	11	9-15	289	19	16-31	135	33	20-37	62	13	8-30	140	22	16-31	101	42	29-49	32	6	7-36	163	17	15-30						
STOUGHTON COMMUNITY HOSPIT STOUGHTON WI 53589	WI-141*	430	13	9-18	36	22	11-41	15	7	12-57	10	10	4-53	24	25	10-43	19	47	24-67	9	11	8-63	30	17	10-40						
SUPERIOR MEM HOSP SUPERIOR WI 54880	WI-142	886	14	9-16	44	27	9-35	41	46	16-44	15	40	5-46	58	21	13-34	65	42	28-53	25	28	4-35	62	13	12-33						

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Dphthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
ST ELIZABETH HOSP APPLETON WI 54911	10	20	5-58	14	29	16-65	46	7	5-25	1	0	0-100	166	6	3-11	48	2	1-17	13	0	0-100	63	3	1-14	162	1	0-6
ST FRANCIS HOSPITAL MILWAUKEE WI 53215	16	25	11-58	47	32	22-53	48	4	4-24	3	0	0-100	280	7	3-9	112	3	1-12	39	0	0-31	117	3	2-11	192	1	0-5
ST FRANCIS MEDICAL CENTER LA CROSSE WI 54601	25	20	11-50	22	23	14-54	68	13	4-19	9	0	0-100	179	6	2-10	71	3	2-16	20	0	0-83	103	6	2-11	152	0	0-6
ST JOSEPH HOSPITAL ARCADIA WI 54612	2	100	0-92	.	.		.	.		.	.		11	0	0-46	6	17	3-65	.	.		8	0	0-56	1	0	0-100
ST JOSEPH'S HOSPITAL CHIPPEWA FALLS WI 54729	7	43	8-71	10	10	16-72	25	8	2-29	12	0	0-90	103	9	2-12	26	8	0-25	7	0	0-97	83	4	2-13	77	0	0-10
ST JOSEPH'S HOSPITAL CHIPPEWA FALLS WI 54729	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
ST JOSEPHS COMMUNITY HOSPI WEST BEND WI 53095	6	33	10-77	2	0	3-91	32	9	3-26	3	0	0-100	107	4	2-11	39	3	0-20	13	0	0-97	48	2	1-16	57	5	0-12
ST JOSEPHS HOSP MARSHFIELD WI 54449	29	10	10-47	27	26	25-63	83	8	6-21	16	0	0-39	352	5	4-10	145	3	1-11	32	0	0-37	425	5	3-8	279	1	1-5
ST JOSEPHS HOSP MILWAUKEE WI 53210	31	32	15-53	14	43	15-64	97	7	5-19	26	4	0-55	415	5	3-9	186	6	2-12	37	0	0-36	504	5	3-7	229	0	1-5
ST JOSEPHS MEMORIAL HOSP HILLSBORO WI 54634	.	.		2	0	1-89	11	9	1-44	.	.		32	0	1-21	12	17	0-49	1	0	0-100	19	11	1-30	15	0	0-68
ST LUKES HOSPITAL MILWAUKEE WI 53215	29	31	11-48	65	35	25-52	63	8	4-20	27	4	0-65	376	6	3-9	158	3	2-12	17	0	0-67	1279	5	3-7	263	2	1-5
ST LUKES HOSPITAL RACINE WI 53403	19	16	9-52	21	52	25-67	28	11	2-26	1	0	0-100	191	7	4-12	23	4	0-28	15	0	0-98	49	2	2-17	66	3	0-11
ST MARY'S HOSPITAL DZAUKEE PORT WASHINGTON WI 53078	4	0	1-76	6	17	8-73	22	5	3-32	.	.		69	3	1-12	29	7	1-24	12	0	0-99	35	0	1-20	61	2	0-12
ST MARYS HOSP MILWAUKEE WI 53211	16	19	8-54	7	14	10-73	34	9	3-25	39	3	0-38	128	2	3-12	78	4	2-15	20	0	0-92	489	8	3-7	80	1	0-9
ST MARYS HOSP SPARTA WI 54656	6	50	7-73	3	33	4-85	4	25	3-76	.	.		42	0	1-18	10	20	1-47	.	.		29	7	1-22	9	0	0-68
ST MARYS HOSPITAL RHINELANDER WI 54501	4	25	3-78	13	8	11-60	32	6	3-27	2	0	0-100	127	3	2-10	26	0	0-26	12	0	0-100	54	7	1-15	87	1	0-9
ST MARYS HOSPITAL MED CTR GREEN BAY WI 54303	5	40	2-71	14	21	15-64	49	12	3-22	2	0	0-100	155	1	2-10	73	4	1-14	9	0	0-100	57	4	1-15	168	1	0-6
ST MARYS HOSPITAL MEDICAL MADISON WI 53715	17	35	11-58	32	19	19-54	87	7	4-17	5	0	0-100	309	3	3-9	150	3	1-11	34	0	0-44	337	7	3-8	300	1	0-4
ST MARYS KEWAUNEE AREA MEM KEWAUNEE WI 54216	1	0	0-98	2	0	6-94	3	0	0-83	.	.		15	0	0-36	1	0	0-99	.	.		10	0	1-46	7	0	0-74
ST MARYS MEDICAL CTR RACINE WI 53405	19	21	6-48	29	34	23-60	60	5	3-19	21	0	0-91	206	6	3-10	138	4	1-11	16	0	0-100	177	5	2-9	175	2	0-5
ST MICHAEL HOSPITAL MILWAUKEE WI 53209	26	35	9-48	18	22	14-58	66	9	4-21	10	0	0-91	285	6	3-9	110	5	2-14	21	0	0-94	117	3	2-11	224	2	0-5
ST MICHAELS HOSP STEVENS POINT WI 54481	19	26	7-49	10	30	15-71	40	15	4-25	4	0	0-100	160	4	2-10	47	2	1-18	7	0	0-98	54	6	2-17	84	1	0-9
ST NICHOLAS HOSP SHEBOYGAN WI 53081	8	75	8-68	21	29	18-60	39	3	2-22	6	0	0-100	151	4	2-10	79	6	1-14	11	0	0-97	65	6	1-14	142	1	0-6
ST VINCENT HOSPITAL GREEN BAY WI 54301	23	43	16-58	28	21	23-61	89	10	4-17	23	0	0-92	252	7	3-10	125	2	1-11	21	0	0-80	99	8	2-12	277	0	0-4
STOUGHTON COMMUNITY HOSPIT STOUGHTON WI 53589	4	0	5-80	5	20	4-72	14	14	2-40	1	0	0-100	59	10	2-16	19	11	1-31	.	.		16	25	1-34	46	2	0-14
SUPERIOR MEM HOSP SUPERIOR WI 54880	10	20	4-57	8	0	9-68	33	3	2-25	.	.		110	6	2-11	49	2	1-17	3	0	0-100	58	3	1-14	35	0	0-22

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																										
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease									
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent						
THEOA CLARK MEM HOSP NEENAH WI 54956	WI-143	2108	9	7-14	154	23	17-35	53	32	18-43	35	11	6-33	87	14	15-34	88	35	28-50	26	27	7-40	110	20	13-29						
TOMAH MEMORIAL HOSPITAL TOMAH WI 54660	WI-144	343	10	10-20	10	50	8-60	16	6	11-54	9	22	5-58	26	23	11-44	14	29	19-68	15	33	7-50	45	16	13-39						
TRI COUNTY MEMORIAL HOSP WHITEHALL WI 54773	WI-145	174	13	10-22	10	50	8-60	10	40	11-64	2	0	1-89	17	24	11-52	9	33	15-72	3	0	0-82	26	15	10-43						
TRINITY MEM HOSP CUOAHY WI 53110	WI-146	1619	13	11-18	113	33	20-40	70	27	19-42	31	23	11-42	154	16	17-32	61	48	26-52	34	18	8-38	126	28	17-34						
TWO RIVERS COMMUNITY HOSPI TWO RIVERS WI 54241	WI-147*	340	16	9-18	19	16	6-43	19	32	16-57	9	44	5-58	19	47	9-47	16	50	21-67	6	33	5-69	27	19	7-38						
UNIVERSITY OF WISCONSIN HO MADISON WI 53705	WI-148	2409	8	8-14	295	15	20-36	25	32	12-47	35	9	10-38	61	23	14-36	58	45	23-48	31	13	9-40	99	23	14-32						
VERNON MEMORIAL HOSPITAL VIROQUA WI 54665	WI-149	491	13	11-20	29	38	17-51	25	28	16-51	17	18	4-41	36	22	13-41	19	68	26-69	21	5	4-39	69	17	12-33						
VICTORY MEMORIAL HOSPITAL STANLEY WI 54768	WI-150*	236	11	9-19	9	22	8-63	7	29	9-70	6	17	6-70	22	27	12-48	5	60	11-81	7	0	4-63	30	17	9-38						
WATERTOWN MEMORIAL HOSPITA WATERTOWN WI 53094	WI-151*	762	13	11-18	38	24	13-43	45	36	17-44	15	20	7-49	47	34	16-42	27	44	26-63	25	20	9-44	61	18	13-36						
WAUKESHA MEMORIAL HOSP INC WAUKESHA WI 53186	WI-152	2139	12	10-16	148	29	18-36	78	31	20-41	54	19	9-33	121	20	17-33	76	38	29-52	46	17	11-38	180	23	15-30						
WAUPUN MEMORIAL HOSPITAL WAUPUN WI 53963	WI-153*	432	13	10-19	26	31	12-46	20	35	14-53	11	18	5-53	44	27	14-39	20	40	20-61	8	13	6-64	37	11	10-37						
WAUSAU HOSPITALS INC WAUSAU WI 54401	WI-154	2398	12	9-15	193	27	16-32	98	34	20-39	43	21	8-33	140	26	16-31	106	32	29-49	40	38	12-41	142	8	12-27						
WEST ALLIS MEMORIAL HOSPIT WEST ALLIS WI 53214	WI-155*	2443	11	9-16	207	18	16-32	114	25	21-39	43	16	7-32	158	21	16-30	94	46	30-51	40	13	8-36	180	16	14-28						
WILD ROSE COMM MEM HOSPITA WILD ROSE WI 54984	WI-156	284	12	9-19	11	27	5-53	15	20	9-52	5	20	1-68	18	6	10-49	19	53	20-62	21	10	5-40	34	32	10-38						

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
THEDA CLARK MEM HOSP NEENAH WI 54956	21	19	14-58	12	17	10-60	32	6	2-25	9	0	0-99	195	3	3-10	96	2	1-13	23	4	0-67	232	5	3-9	250	1	0-4
TOMAH MEMORIAL HOSPITAL TOMAH WI 54660	7	29	8-71	2	0	1-89	4	25	1-74	.	.		36	0	1-19	11	0	2-45	1	0	0-100	25	0	1-24	16	0	0-46
TRI COUNTY MEMORIAL HOSP WHITEHALL WI 54773	1	0	0-97	3	0	3-83	1	0	0-100	1	0	0-100	19	0	1-30	2	100	1-89	.	.		8	0	0-61	4	0	0-100
TRINITY MEM HOSP CUDAHY WI 53110	10	20	6-60	16	31	15-61	35	11	4-27	4	0	0-91	176	5	4-12	54	6	2-18	10	0	0-98	152	1	2-10	107	2	1-8
TWO RIVERS COMMUNITY HOSPI TWO RIVERS WI 54241	7	0	5-67	5	40	4-72	19	11	2-34	.	.		47	9	1-17	16	0	0-36	4	0	0-100	19	16	1-31	25	0	0-29
UNIVERSITY OF WISCONSIN HO MADISON WI 53705	91	8	4-32	3	67	9-90	32	19	2-24	182	1	0-4	158	8	5-15	86	2	1-13	28	0	0-41	204	5	3-9	160	1	0-6
VERNON MEMORIAL HOSPITAL VIROQUA WI 54665	9	22	5-62	9	11	12-69	3	0	1-81	.	.		54	4	2-16	15	0	0-39	1	0	0-100	33	3	1-20	26	4	0-27
VICTORY MEMORIAL HOSPITAL STANLEY WI 54768	3	67	4-86	4	25	6-81	1	0	0-100	.	.		37	5	1-19	7	0	0-58	3	0	0-100	14	0	1-37	14	0	0-52
WATERTOWN MEMORIAL HOSPITA WATERTOWN WI 53094	6	50	11-79	8	25	13-73	24	0	3-32	2	0	0-100	94	6	3-14	34	3	1-22	7	0	0-98	46	0	2-18	50	2	0-14
WAUKESHA MEMORIAL HOSP INC WAUKESHA WI 53186	18	28	6-49	20	25	21-64	41	17	2-21	10	10	0-98	237	5	3-10	101	10	2-14	16	0	0-100	128	5	2-11	125	1	0-7
WAUPUN MEMORIAL HOSPITAL WAUPUN WI 53963	6	33	9-76	4	0	4-78	9	0	2-50	.	.		54	6	3-19	17	12	0-34	4	0	0-100	26	12	1-23	31	0	0-24
WAUSAU HOSPITALS INC WAUSAU WI 54401	13	23	9-59	21	38	20-62	88	13	5-19	28	0	0-87	255	7	3-9	85	2	0-14	27	0	0-95	198	4	2-9	253	2	1-5
WEST ALLIS MEMORIAL HOSPIT WEST ALLIS WI 53214	19	26	8-51	21	19	17-58	70	4	3-19	9	0	0-99	315	5	3-10	135	1	1-11	47	0	0-39	125	7	2-11	225	1	0-5
WILD ROSE COMM MEM HOSPITA WILD ROSE WI 54984	4	25	2-76	6	17	7-72	13	0	1-40	.	.		33	0	0-20	11	0	0-49	3	0	0-100	28	0	1-22	10	0	0-70

*Written Comments Not Submitted.

Barron Memorial Medical Center, Inc.

Gerald C. Olson, N.H.A.
Administrator

Kathleen S. Steel
Asst. Administrator

October 23, 1987
COMMENTS ON HCFA MORTALITY DATA
Barron Memorial Medical Center, Barron, Wisconsin

Data Verification

The data used by HCFA indicate that a total of 51 Medicare patients admitted to Barron Memorial Medical Center died within 30 days of admission. Of these, 31 died while still a patient of the hospital, while 20 died after discharge. HCFA data indicate a total of 472 Medicare admissions for 1986. Our own records indicate that 745 Medicare admissions occurred in 1986. Because HCFA data includes only the last admission for each Medicare beneficiary in 1986, presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hosptials. We have no way of verifying whether the number of Medicare patients indicated by HCFA as treated at Barron Memorial Medical Center is correct. It is impossible to determine the percentage of the 20 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in the analysis.

Interpretive Remarks

In four of the diagnostic categoris, the hospital's actual mortality rate falls below the range of the predicted mortality rate. Of the remaining diagnostic categories, the hospital's actual mortality rate is within the predicted mortality rate developed by HCFA.

Although data for Barron Memorial Medical Center has not identified any problem in mortality rates, it is important to keep in mind that HCFA's mortality rates should be used only as a statistical analysis of estimated mortality rates. The information is not a measure of hospital performance. Under no circumstance should it be used as the basis for judging the quality of care provided at Barron Memorial Medical Center. The following points should be kept in mind when analyzing the data:

1.) The mortality rates are based on any deaths occuring in the hospital or within 30 days after admission. Because some of the deaths occur after discharge, the death may be unrelated to the condition of the patient that was under treatment at the time of discharge. The death may also be the result of management of the patient at home or in a post-acute care facility.

2.) The model used to develope the "range of predicted mortality rates" fails to consider a wide range of factors with a significant impact on mortality. These factors include: The patient's general health status, the stage of the patient's illness, the patient's psychological condition and family support. The second, and more serious limitation of the model is that it has never been validated.

Respectfully Submitted,

Gerald C. Olson, Administrator

1222 Woodland Avenue – Barron, Wisconsin 54812 – Phones - Barron -- 715-537-3186 – Chetek 715-924-4848

BELOIT MEMORIAL HOSPITAL

Affiliated with the University of Wisconsin Hospital and Clinics.

October 21, 1987

Medicare Provider Number:
52-0100

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper,

Beloit Memorial Hospital is providing the Health Care Financing Administration with supplemental information relative to the HCFA 1986 Mortality Report dated September 21, 1987. The Mortality Report inaccurately indicated a higher than predicted mortality rate for patients at Beloit Memorial Hospital with the diagnosis of severe acute heart disease. This supplemental information will enable your agency to more accurately present the mortality data for Beloit Memorial Hospital patients with severe acute heart disease.

Your report claims that 63 Medicare patients with the diagnosis of severe acute heart disease were treated at Beloit Memorial Hospital. Your report further claims that 35 of these patients died at Beloit Memorial Hospital resulting in a mortality rate of 59% which is beyond your range of the predicted mortality rate of 28% to 53% for patients with this diagnosis. Your mortality report fails to take into account special considerations and circumstances which are completely beyond the control of any hospital provider.

A thorough review by our medical staff leadership of the medical records of the patients included in your mortality report revealed the following facts which are not reflected in your report:

1969 West Hart Road, Beloit, Wisconsin 53511 (608) 364-5011

- 14 patients died within 24 hours of admission, most of them died within a few hours of their arrival to the hospital due to their poor medical condition upon arrival which precluded their survival. These patients did not receive cardio-pulmonary resuscitation until paramedic personnel arrived and were transported to Beloit Memorial Hospital while being resuscitated. A recent study indicates that the mortality rate for these patients exceeds 85% and increases substantially with delays in receiving medical attention.

- [redacted], suffered a ruptured abdominal aortic aneurysm. This patient had refused treatment after being diagnosed at another local hospital earlier on the day of admission to Beloit Memorial Hospital. The patient, who had no history of heart disease, was brought to our hospital by a family member later in the evening where she died as a direct result of her ruptured aneurysm.

- One patient refused to be transferred to an interventional cardiology center for further treatment and instead chose to remain at Beloit Memorial Hospital against medical advice.

- 13 patients or their families requested that no "heroic life support" measures be undertaken, considering their cardiac events to be the natural end of their lives.

- [redacted]had been discharged from the University of Wisconsin Hospital and Clinics for coronary bypass surgery ten days prior to admission to Beloit Memorial Hospital. She was admitted to Beloit Memorial Hospital with a complaint of nausea and significant changes in her EKG. She suffered an acute myocardial infarction secondary to bypass graft occlusion.

- All of the patients included in your mortality statistics were severely ill and had several high risk factors which are clinically considered to confer a poor prognosis and included:

  - Histories of progressive heart disease
  - Hypertension
  - Diabetes Melitus
  - Severe Chronic Obstructive Pulmonary Disease
  - Chronic Renal Failure

- The average age of the Beloit Memorial Hospital patients included on your 1986 mortality statistics with a diagnosis of severe acute heart disease was 75.8 years. The life expectancy of the average American was 73 years in 1986.

Based on our data, 61 patients were actually admitted to Beloit Memorial Hospital with the diagnosis of severe acute heart disease, not 63 as indicated in your report. Thirty-three of these patients died, not 35, as a result of conditions and circumstances which were beyond the control of any hospital or physician for an actual mortality rate of 54%.

The above considerations and circumstances indicate that the Beloit Memorial Hospital patients included in your 1986 mortality report were severely ill at the time of their admission to Beloit Memorial Hospital and had poor prognostic factors associated with their health. These uncontrollable factors are not incorporated into the mortality methodology developed by HCFA. It would be completely inaccurate to use the 1986 Mortality Report as an assessment of the quality of care and treatment received by patients at Beloit Memorial Hospital.

Sincerely yours,

Michael E. Rindler
President

MER:ph

BLACK RIVER
MEMORIAL HOSPITAL

711 WEST ADAMS STREET
BLACK RIVER FALLS, WI 54615
(715) 284-5361

SPECIALISTS IN FAMILY CARE.

October 21, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Gentlemen:

We have received and reviewed our hospital specific mortality data and find it to be accurate; but would offer the following comments and observations:

Our internal Quality Assurance Committee routinely reviews all deaths at our hospital in the broader context of the entire medical record. Even though our actual mortality rates fall within predicted ranges for our facility in all diagnostic catagories, we would hesitate to form any quality conclusions based on these rates. Statistical mortality analysis is only useful in identifying potential areas for review and cannot be used as a measure of quality.

There is also a potential problem with the data due to the fact that our numbers are so small that there is no real statistical significance in any diagnostic category.

We caution that this data alone should not be used as a basis for judging the quality of care provided by hospitals.

Sincerely

R. L. Wiste

Roger Wiste
Administrator

Calumet
Medical Center
Your health is our first concern.

614 Memorial Drive
Chilton, WI 53014
414-849-2386

Medicare Provider Number: 520115

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. William Roper, M.D.:

Enclosed is our response to the planned December 1987 news release by the Health Care Financing Administration (HCFA), of selected mortality information pertinent to our facility.

We would like to bring to your attention one error regarding the Date of Discharge for [redacted] as reported in our Hospital Specific Information. This patient is listed with a Discharge Date of 08/17/86 and a Date of Death of 08/18/86. In actuality the Date of Discharg is 08/18/86, the same date the patient expired.

Thank you for allowing us the opportunity to comment and participate prior to the publication of this information.

Sincerely,

Joseph L. Schumacher
Administrator

JLS:mg
enc:

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Calumet
Medical Center
Your health is our first concern.

614 Memorial Drive
Chilton, WI 53014
414-849-2386

Medicare Provider Number: 520115

October 23, 1987

RESPONSE TO HCFA MORTALITY RELEASE

The recently released HCFA mortality data indicates Calumet Medical Center is well within the predicted normal range. Despite this and other findings that show positively for the medical center, Calumet Medical Center does not support indiscriminate distribution of the HCFA data to the public. This is because interpretation of the data is difficult and best left to a technical audience, not the general public. At the very least, the general public should be educated not to use the data as a basis for judging quality care.

HCFA has used a complicated statistical method for estimating expected mortality over a 30-day period, including post-discharge death rather than identifying an inpatient mortality rate. Using a 30 day post admission time span can be misleading as this will result in attributing to the facility, deaths unrelated to the condition for which the patient was treated prior to discharge, as well as conditions that resulted from the management of the patient at home or in a post acute care facility.

The HCFA data indicates that out of 387 Medicare cases treated at Calumet Medical Center during 1986, 59 died within 30 days of admission. In actuality, 47 were in-hospital deaths, 4 deaths occurred in the Swing Bed unit which is comparable to the highest skill-level nursing home and 8 patients died after discharge. Our records also indicate that Calumet Medical Center had 577 Medicare acute care admissions and 61 Swing Bed admissions in 1986 for a total of 638 as compared to the 387 cases used by HCFA in their report.

Of significant interest in analyzing the HCFA data is the fact that 25.4% of the deaths happened within 24 hours of admission to the medical center and the average age of these individuals was 87 years. Given these findings, it is apparent that consideration must be given to both an individual's condition on admission as well as his/her age. One of the admitted failures of the HCFA statistical model is that it does not include measures of severity, (i.e., how ill the patient was at the time of admission, whether the patient was transferred to the hospital from a nursing home, whether the patient was receiving treatment at home prior to admission, whether the patient had a terminal illness or the patient's psychological state or general health status). According to the latest statistics available from the National Center for Health Statistics, the average life expectancy for Americans, both male and female, is 74.7 years.

There are approximately 275 to 300 nursing home beds within a 7 mile radius of Calumet Medical Center. This may account for the fact that 39% of the reported deaths were admitted from nursing homes. It is also important to note that careful review of our records reveals that due to the stage of illness, the presence of complicating conditions and/or the general condition of the patient on admission, death was the anticipated and unavoidable outcome in 80% of the reported cases. In other words these patients were admitted for terminal care.

Appropriate analysis of a hospital's level of care can not be made without assessing the role of Quality Assurance. Quality Assurance has been and continues to be an ongoing important function at Calumet Medical Center. The medical center's Quality Assurance Committee is a multidisciplinary approach, designed to monitor and review all patient care and treatment, including the routine review and analysis of mortalities. Each department within the hospital has a quality assurance plan; quarterly reports are submitted by department to the Quality Assurance Committee composed of representatives from the medical staff, nursing service, administration and other major departments. Conclusions regarding deficiencies in care can never be made solely on outcome measures, because a poor outcome can result when there have been no deficiencies in complying with accepted standards of care. The value of a quality assessment method lies in its ability to identify remediable deficiencies in patient care for which corrective action can be instituted. Because various factors contribute to illness and ultimately death, mortality data in themselves can not be used as measures of quality.

In conclusion, we welcome the opportunity to respond to HCFA and the general public regarding these statistics and intend to continue to do so in the future.

2025 East Newport Avenue
Milwaukee, WI 53211
414-961-3300

Medicare Number: 52-0140

Columbia Hospital

October 22, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

TO: Health Care Financing Administration

The data used by Health Care Financing Administration indicate that a total of 297 out of 2971 Medicare patients admitted to Columbia Hospital died within 30 days of admission. Columbia Hospital data indicate that more Medicare admissions occurred at Columbia in 1986. The differences in admission data are presumably due to multiple admissions and patients admitted to other hospitals. The HCFA data relating to Columbia Hospital deaths is correct. No assessment can be made regarding patients treated at other hospitals.

The statistical model developed by HCFA, perhaps an improvement over raw mortality data, has not been validated. Furthermore, the model does not take into consideration all risk factors and may not take into consideration the most important risk factors. Mortality data are only one factor in assessing a hospital's performance. For these and other reasons, judging overall quality of care of an institution based on these HCFA data is inappropriate.

Sincerely,

John F. Schuler
President

mep

October 27, 1987

William L. Roper, M.D.
Administrator
Healthcare Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

We have reviewed the mortality information about Medicare patients treated in our hospital in 1986. Our overall mortality rate, and our rates for each of the diagnostic categories are within HCFA's range of predicted mortality rates.

The data used by HCFA indicates that a total of 132 patients admitted to Community Memorial Hospital died within thirty (30) days of admission. Of these, 106 died while still a patient in the hospital while 26 died after discharge. It is not possible to verify the cause of death for those patients who were alive at the time of discharge since information concerning death after discharge is not included in the patient's hospital medical record, nor is it readily accessible to us.

Our overall mortality rate falls to 8% from 10% after the 26 post discharge deaths are deleted from the appropriate diagnostic categories. The following table reflects this adjustment:

Category	Including Post Discharge Death Death/Rates	Excluding Post Discharge Deaths Death/Rates
All Causes	132/10%	106/8%
CA	27/27%	21/21%
CE	19/38%	16/32%
EY	0/ 0%	Unchanged
GC	2/ 7%	Unchanged
GI	5/ 3%	3/ 2%
GU	0/ 0%	Unchanged
GY	0/ 0%	Unchanged
HL	3/ 4%	1/ 1%
HM	12/18%	10/15%
HS	15/33%	13/29%
ME	2/ 8%	Unchanged
OP	2/ 2%	1/ 1%
PN	14/17%	12/15%
RN	2/40%	Unchanged
SE	3/30%	Unchanged
TR	2/ 5%	1/ 3%
UN	24/HCFA (did not compute rate)	19/14%

Our own records indicate that 1,902 Medicare admissions occurred in 1986, whereas the HCFA report indicates a total of 1,268 admissions. We are unable to determine the reason for this discrepancy because HCFA did not provide us with a detailed listing of the 1,268 cases.

We thank you for the opportunity to review this data prior to its disclosure and for including our comments as part of the final publication.

Sincerely,

Robert E. Drisner
President

RED/skg
Medicare Provider No. 520103

cc: P. Parker, Vice President
D. Hoyt, Marketing Director

Diane Ebersberger, Director, Prof. Pract.
Wisconsin Hospital Association

Marvin F. Neely, Jr., President
Hospital Council of Greater Milwaukee Area

Elmbrook
MEMORIAL HOSPITAL

October 13, 1987

Elmbrook Memorial Hospital ID # 520170

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Elmbrook Memorial Hospital supports HCFA's efforts to provide meaningful quality of care data to the public. However, we would like to offer some constructive comments regarding the statistical model for predicting mortality rates.

Not unexpectedly, Elmbrook fell within all of the predicted mortality ranges in HCFA's 1986 report. Verification of the HCFA data with Elmbrook Memorial Hospital's medical records has revealed the following:

HCFA has identified 1,016 Medicare cases for inclusion in the analysis. Hospital records indicate a total of 1,532 Medicare admissions in 1986. Presumably the HCFA number is lower because only the last admission is included for patients with multiple admissions during the year, but the Hospital has no way to verify that HCFA's lower number truly relects the total number of Medicare patients treated at Elmbrook in 1986.

HCFA has reported 109 deaths in the 1,016 cases treated at Elmbrook Memorial Hospital. Eighty-seven of these 109 died while still a patient, while 22 died after discharge. These 22 cases represent 20 percent of the total Medicare deaths included in Elmbrook's statistics. The majority of the 22 Medicare patients that died after discharge had been transferred to nursing homes. Seventeen of the 22 deaths were verified with nursing homes, where the deaths were not unexpected.

In the diagnostic category "Sepsis," HCFA data reveals a 50 percent mortality rate, 4 out of 8 cases, for Elmbrook Hospital. The 50 percent rate is within the predicted range of 12 to 72 percent, but it is worth noting that verification of data revealed that 3 of the 4 deaths (75 percent) occurred after discharge from Elmbrook Hospital, and that 2 of the 4 patients (50 percent) died after discharge from causes other than sepsis. (One death after discharge could not be verified.) The current methodology for relating deaths to a particular hospital or diagnosis can provide an inaccurate picture, especially when the number of data elements is small.

19333 West North Avenue
Brookfield, WI 53005-4198
414-785-2000

A Member of the Wheaton Franciscan System

Elmbrook Memorial Hospital considers it important that the public be informed of the limitations of the model in denoting the quality of hospital care. These statistics apply to Medicare cases only and cannot be generalized to the public. The HCFA model uses only five patient factors to predict mortality rates and fails to consider a wide range of other factors, including severity of illness, that may influence the risk of death. Even the most carefully devised model for predicting mortality rates will provide only a screen for further review. Ultimately, quality of care judgments must be made through review of individual medical records.

We hope these comments will be useful in refining the statistical model for future use.

Sincerely,

Stephen R. Young
President

SRY:de

fort atkinson memorial hospital
MOVING AHEAD IN FAMILY CARE

Ocotber 21, 1987

William L. Roper, M.D., Administrator
Healthcare Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

Fort Atkinson Memorial Hospital has carefully reviewed our hospital's specific 1986 mortality information which you furnished on September 21, 1987.

While our hospital was within predicted mortality rates for all categories, we are troubled by several aspects of the information and wish to comment on these areas.

These areas of concern include 1) the inability to verify actual causes of death of some individuals who died after discharge, 2) the methodology to determine predicted mortality rates is questioned when predicted ranges were 0 to 99%, 0 to 96%, 1 to 82% or 14 to 65% for four of the categories, 3) the reliability of the model used appears not to be validated, 4) of especial concern was the absence of severity of illness or case mix as factors, and 5) that deaths were attributed to principle diagnosis/DRG rather than actual case.

We recognize mortality rates and deaths are of themselves neutral and indicate neither good nor poor quality of care. They are an indicator which needs further review to determine if appropriate or inappropriate care was rendered. While you have disclaimers to that in the material to be released, as a practical matter, the media and general public will interpret the raw data as good or poor care rather then an indicator.

We agree the public has a right to know mortality rates; it is a concern that the data will be misinterpreted.

Sincerely,

John C. Albaugh
President

JCA/jm

cc: Marjorie Redford, R.N., Quality Assurance Coordinator

C. L. JUNKERMAN, M.D.
Sr. Vice President
Academic and Professional Affairs



FROEDTERT MEMORIAL LUTHERAN HOSPITAL

October 12, 1987

Medicare Provider # 52-0177

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D.C. 20201

Re: Letter of 09/21/87 in re:
Mortality Information

Dear Dr. Roper:

We appreciate the opportunity to examine and comment upon the specific Medicare mortality data for our hospital prior to publication of the information generally.

Review of the data for Froedtert indicate that they are accurate. We should like to comment specifically about patients in the category of sepsis, the only area in which we exceed predicted mortality rates based upon percentage. Here, the use of percentage alone would be misleading because of the small number of patients. Examination of these cases in detail reveal that two of the six were elderly patients (79 and 87) who were admitted from nursing homes; one who was described on admission to the emergency room as "moribund" died 0 hours after admission, the other died 13 hours after admission.

As a physician, you are aware that patients with a major diagnosis of sepsis almost always have multiple problems (including immunosuppression). Those who die within 24 hours of admission usually have not provided the medical facility an adequate time opportunity to reverse the process. If the two patients who died less than 24 hours after admission were not counted, our hospital's percentage in this category would be 50%, well within range.

Your cover letter quite properly acknowledges the difficulty in making judgments when ways of dealing with the issue of severity of illness have not been developed. Until severity parameters can be factored into the equation, institutions such as ours, which are tertiary care teaching hospitals, will continue to be disadvantaged by publication of mortality statistics that do not consider this critical factor.

We note and applaud your statement that you "can not and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals". We know that it is likely that such a disclaimer will accompany public release of the hospital mortality information but we are concerned that the general public, the press and perhaps even the peer review organizations will not take notice of the caveat and will, indeed, make unwarranted value judgments on the basis of the published data alone.

Thank you for the opportunity to make these comments.

Sincerely yours,

C. L. Junkerman, M.D.

CLJ:rjr

Hayward Area Memorial Hospital
Hayward Nursing Home
Telephone: (715) 634-8911
Route 3, Box 3999
Hayward, Wisconsin 54843

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

RE: MEDICARE PROVIDER # 52-0161

Dear Doctor Roper,

Thank you for sharing the Medicare mortality data for 1986 which you plan to release to the public. It was helpful to have the opportunity to examine the data prior to its release.

I am responding for the Hayward Area Memorial Hospital. I have only two brief comments about the data. The first relates to deaths noted to be secondary to cancer. Our data shows that we had ten cancer deaths, or a forty percent mortality rate. Of interest is the fact that our facility is a small forty-one bed acute care facility located in a rural area. We provide no advanced cancer treatment, but do provide a good deal of end-stage hospice-type care. Many of the patients who have been diagnosed and treated in other facilities are admitted to this facility to receive that care in a setting closer to their homes and families. I feel that contributes greatly to the mortality rate in that diagnostic category.

My second point deals with the fact that, if you examine the numbers for our facility, you will see that we have a very low number of total cases. I believe that makes the percentages less reliable than when there is a large sample. For example, in the Urologic Disease category, the total number of cases is noted to be five, with an actual mortality rate of twenty percent.

Thank you for the opportunity to relay these comments to you, and again, thank you for sharing this information in advance.

Sincerely,

Barbara A. Peickert

Barbara A. Peickert
Chief Executive Officer

BP/kh

Good Samaritan Health Center

601 Center Avenue South Merrill, Wisconsin 54452 715-536-5511

Acute Care (Hospital)
Medical
Surgical

Anesthesia

Echocardiography

Emergency Room Service

Home Medical Equipment
Sales
Rentals
Service

Obstetrics
Birthing Room
Nursery
Rooming In

Outpatient Services
Ambulatory Surgery
Specialty Consultations
Cardiology
Ear, Nose & Throat
Gastroenterology
Neurology
Oral & Maxillofacial Surgery
Urology

Pastoral Care

Patient Education

Radiology
Diagnostic Fluoroscopy
CT Scanning
Mammography
Nuclear Medicine
Ultrasound

Rehabilitation Services
Occupational Therapy
Physical Therapy
Speech Therapy

Respiratory Care

Social Services

Special Care Unit
Cardiac Rehab

Stress Testing

Surgery

Swing Beds (Skilled Nursing)

Women's Health Issues
Childbirth Education
PMS Clinic

Anatomical Pathology

Clinical Laboratory

COMMENTS ON THE HCFA MORTALITY DATA
GOOD SAMARITAN HEALTH CENTER, MERRILL, WI - 520015
(formerly Holy Cross Hospital)

DATA VERIFICATION

The data used by HCFA indicate that a total of 53 Medicare patients admitted to Good Samaritan Health Center in 1986 died within 30 days of admission. Of these, 41 died while still a patient of the Health Center, including patients treated in the Swing Bed program, while 12 died after discharge. Our own records indicate that 885 Medicare admissions occurred in 1986, while HCFA reports only 505 Medicare admissions. This discrepancy reflects multiple admissions of individual Medicare beneficiaries to different hospitals (HCFA statistics only include the last admission for patients hospitalized more than once during the year.)

UNIQUE SERVICES

It must be noted that the mortality statistics include patients treated not only in our acute care Health Center but also in our Swing Bed program where patients are sometimes treated for terminal care as well as other post-acute skilled nursing care.

R. Joe Younker, FACHE
President/CEO
October 21, 1987

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

HUDSON MEMORIAL HOSPITAL

Hudson, WI

COMMENTS ON THE HCFA MORTALITY DATA

Data Verification

The data used by HCFA indicate that a total of 62 Medicare patients admitted to Hudson Memorial Hospital died within 30 days of admission. Of these, 4 were Swing Bed patients. Of the 58 patients, 46 died while still a patient of the hospital, while 12 of these patient died after discharge. Of these 12, 5 were transferred to nursing homes, 3 were cancer patients, 1 was transferred to another acute care facility, 1 went home and then was admitted to another acute care facility for tests, while there he expired. 1 patient was listed as having died after discharge but died in the hospital. See attached correction. 1 patient was discharged to home and expired and 1 patient was discharged and returned to our Emergency Room and expired.

Our records show that there were 429 Medicare admissions to Hudson Memorial Hospital. This would make our actual mortality rate, by Medicare patients, 14.5%. This would fall within HCFA's "range of predicted mortality rate", which is 9 to 19%.

30 of the patients that died were Hospice/cancer patients which is over 50% of the total Medicare deaths. If the Hospice/cancer patients were removed from the total deaths, the actual hospital Medicare mortality rate would be 7%.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

308 East Fourteenth Street
Kaukauna, Wisconsin 54130

414/766-4211

Kaukauna Community Hospital

Comments on the HCFA Mortality Data
Kaukauna Community Hospital, Kaukauna, WI
Medicare Provider Number: 52 - 0141

Upon inspection of the data generated and presented by HCFA relating to patient mortality many questions pertaining to accuracy and relevance of numbers can be raised.

Information of this type presented to the public can lead to false perceptions of quality of care provided by individual hospitals. This information cannot be used or presented as a measure of hospital performance. Consideration of individual cases is not a part of the data gathered and therefore inaccuracies occur and proper identification of meaningful categories cannot be made.

The first of these factors is the individual patient's health status. Obviously the survival rate of individuals with a generally healthy history may be greater than that of patients who have a history of underlying health problems (diabetes, COPD, heart disease, etc). These items are not considered during the accumulation of the HCFA data.

The second factor affecting mortality rate is the stage of illness which a patient enters the hospital setting. Again, patients admitted with a prolonged acute or end-stage diagnosis may not have as great a survival rate as those patients admitted in the early stages of a disease or medical problem. This factor is also not considered during the accumulation of the HCFA data.

A third factor is deaths after discharge not related to the diagnosis for which care was provided in the hospital up to 30 days prior to the death. Data is accumulated by the principal diagnosis for the last hospital stay prior to death and the actual cause of death never enters into the HCFA analysis.

A fourth and final factor which skews the accuracy of the presented data is the size of the sample available from small hospitals. When sample size is small, factors as mentioned above may have an even greater impact on data accuracy. On an annual basis one case impacted by an above factor affects the results from our hospital greatly. Each case represents an average of 7.2% of the cases in each diagnostic category. In forty percent of the individual categories one case represents ten or more percent of the sample.

Kaukauna Community Hospital is proud of the fact that we fall within the predicted mortality ranges for 15 of the 16 diagnostic categories. The category for which we exceed the range has a sample size of two cases and therefore is not large enough to make a determination as to the validity of the results.

Although Kaukauna Community Hospital recognizes the results of the study show conformity with HCFA standards for mortality rates, I feel this information is not suited to be released to the public which does not understand the above mentioned factors and could be misled into making inaccurate judgements as to the health care available in their community.

Sincerely,

Jeffrey K. Jenkins
President
KAUKAUNA COMMUNITY HOSPITAL

KMH
Kenosha Memorial Hospital

6308 Eighth Avenue
Kenosha, WI 53140-5082
(414)656-2011

Richard O. Schmidt, Jr.
President

October 23, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

SUBJECT: MORTALITY DATA FOR KENOSHA HOSPITAL AND MEDICAL CENTER

Reference: Letter, W. Roper to R. Schmidt, September 21, 1987

Dear Mr. Roper:

We have received and reviewed the 1986 Medicare mortality information for Kenosha Hospital and Medical Center and offer several comments in response to our data.

We have identified errors in the data sent to us. Attached is a list of the errors we discovered. Bills for the patients who expired here were reviewed to determine that the correct codes were entered regarding patient discharge status.

We are concerned that the publication of mortality data by HCFA will cause misperceptions by Medicare beneficiaries and the public in general about the quality of care provided at hospitals. The release of the data implies that mortality rates are quality indicators when the real value is in their use to guide or focus peer review. Quality can only be evaluated through a number of processes including peer review; evaluation cannot be limited to statistical comparisons.

We are pleased to see that the mortality rates for Kenosha Hospital and Medical Center fell within the predicted ranges in all categories. While we have serious reservations about the use of mortality rates as an evaluation mechanism, this information will be incorporated into our Quality Assurance Program in an attempt to continue to provide a high quality of medical care.

We appreciate the opportunity to provide a response in advance of the data release and look forward to continuing efforts on behalf of HCFA to cooperate with hospitals as quality of care data is developed.

Sincerely,

Richard O. Schmidt, Jr.

Richard O. Schmidt, Jr.
President

ROS/pd
Attachment

ERRORS IDENTIFIED IN HCFA MORTALITY REPORT
KENOSHA HOSPITAL AND MEDICAL CENTER

Patients on the HCFA list that were not patients at Kenosha Hospital and Medical Center:

HIC	LAST NAME	ADM. DATE	DIS. DATE
[redacted]	[redacted]	2/8/86	2/16/86
[redacted]	[redacted]	8/17/86	9/13/86

Patients who expired at Kenosha Hospital and Medical Center in 1986 that were not on the HCFA Mortality Report:

HIC	LAST NAME	DISCHARGE DATE
[redacted]	[redacted]	1/13/86
[redacted]	[redacted]	2/2/86
[redacted]	[redacted]	2/16/86
[redacted]	[redacted]	4/6/86
[redacted]	[redacted]	5/3/86
[redacted]	[redacted]	5/10/86
[redacted]	[redacted]	5/10/86
[redacted]	[redacted]	6/13/86
[redacted]	[redacted]	7/9/86
[redacted]	[redacted]	7/10/86
[redacted]	[redacted]	7/15/86
[redacted]	[redacted]	7/20/86
[redacted]	[redacted]	11/24/86

KMH
Kenosha Memorial Hospital

LUTHERAN HOSPITAL

LA CROSSE

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
PO Box 26684
Baltimore, Maryland 21207

Subject: Comments on HCFA Mortality Data
Medicare Provider Number: 520087

Dear Dr. Roper:

The mortality rate of Lutheran Hospital-La Crosse was within parameters for all categories. Our review of HCFA mortality data found three admissions that were incorrectly included as having died within thirty days of admission. Two of the patients are still living. Those cases are [redacted] and [redacted] in categories OP and HM, respectively. In category [redacted] the correct date of death is September 29, 1986 rather than August 29, 1986.

There were three other errors in the date of death. The corrected dates of death are as follows: Category [redacted] DOD: February 19, 1986; [redacted] DOD: February 9, 1986; and, Category CA, [redacted] DOD: April 23, 1986.

Lutheran Hospital is a regional referral center and teaching hospital with more than two hundred physicians and dentists providing specialty care to nineteen surrounding counties in three states. Among the specialty services to which referrals are made are: cardiology, cardiothoracic surgery, cancer care, rehabilitation, renal dialysis, trauma, obstetrics, and neonatology. In addition to medical education, the Hospital supports training programs for over three hundred nursing students and over four hundred health care professionals in other fields.

The provision of quality care to hospital patients is the objective to which we dedicate ourselves. A comprehensive review of the quality of care provided necessitates an examination of many variables. Mortality review is one of the quality indicators. However, a low mortality rate does not, by itself, indicate quality care, nor does a high mortality rate indicate a problem. To determine whether a problem exists, case-by-case review must be conducted. At Lutheran Hospital, ongoing Medical Staff mortality review is performed at mortality conferences and interesting case presentations.

1910 South Avenue, La Crosse, Wisconsin 54601-9980, Telephone (608) 785-0530

The Hospital and its Medical Staff's commitment is displayed through its ongoing quality assurance program which monitors over fifty-three indicators. A medical education teaching program holds daily conferences where Medical Staff and over one hundred guest lecturers deliver presentations. The teaching program generates the most intense form of quality control - peer review. Young doctors and medical students participating in the education program bring with them the most current medical knowledge. As they apply that knowledge to the care of patients, they ask endless questions of the Medical Staff teaching physician. Physicians willing to put their skills and knowledge on the line are attracted to this kind of creative atmosphere.

Sincerely,

LUTHERAN HOSPITAL-LA CROSSE

Donald Smith

Donald Smith
Senior Vice President

sk

LAKELAND HOSPITAL

October 21, 1987

William L. Roper, M. D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

We are responding to your September 21, 1987 letter and mortality statistics for Lakeland Hospital, provider number 520102.

Data Verification

The following cases are erroneously listed as deaths following discharge when in fact the death occurred while hospitalized: [redacted]. Case [redacted] was readmitted and died during that subsequent admission. [redacted] date of discharge and date of death is 9/07/86. Our review of all other patient information, to the degree we could confirm, is correct.

Specific Diagnostic Category Comments

Cancer: Of the cancer deaths reported, 48.3% (14) were patients of the Lakeland Hospice Program.

Orthopedic Disorders: The one death reported here involved a patient who had generalized carcinomatosis and the prognosis was bleak at the time of discharge.

Renal Disease: The one death in this category concerned a patient who was discharged to a nursing home for terminal care because of progressive deterioration due to renal failure and diabetes.

Our overall mortality rate is within the predicted ranges both with respect to all causes as well as individual diagnostic categories. When considering the 14 hospice deaths and excluding them from the mortality rate calculations, the actual mortality rate then becomes 16% rather than 31% and the All Causes rate is reduced to 12%.

Thank you for the opportunity to comment upon this data release packet.

Sincerely,

William H. Lange

William H. Lange
Administrator

WHL:rw

P.O. Box 1002 Hwy NN Elkhorn, WI 53121 414-741-2000

LAKEVIEW HOSPITAL
10010 W. BLUE MOUND RD. ● MILWAUKEE, WISCONSIN 53226
TELEPHONE 771-5200

COMMENTS ON THE HCFA MORTALITY DATA
Lakeview Hospital, Milwaukee, WI

INTERPRETIVE REMARKS

The data supplied by HCFA for a predetermined period indicates that a total of 47 Medicare patients admitted to Lakeview Hospital died within 30 days of admission. Of these, 38 died while still a patient of the hospital, while 9 died after discharge from the hospital.

It is not possible for the hospital to determine the circumstances or accuracy of the data related to the 9 after discharge cases, as this information is not included in the patients' medical records.

Of the 38 expirations within the HCFA listed diagnostic categories occurring at Lakeview Hospital, all deaths fall within the HCFA range of predicted mortality rates.

It would appear reasonable not to generalize from this HCFA data, as in the majority of diagnostic categories there were an insufficient number of cases to allow for statistical significance. As stated by William L. Roper, M.D., Administrator, Health Care Financing Administration, "While we believe that information on hospital mortality rates is useful, until we have developed additional statistical measures to deal with complex issues such as severity of illness, we cannot and do not recommend the use of the information by itself to make judgments about the quality of care in an individual hospital or to make comparisons among hospitals".

10/12/87

J. E. Race Cedmin.
J. E. RACE, Administrator

MEMORIAL HOSPITAL

October 19, 1987

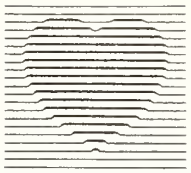
COMMENTS ON THE HCFA MORTALITY DATA
Memorial Hospital, Manitowoc, Wisconsin
Medicare Provider #520081

Data Verification

The data used by HCFA indicate that a total of 76 Medicare patients admitted to Manitowoc Memorial Hospital died within 30 days of admission. Of these, 60 died while still a patient of the hospital, while 16 died after discharge. While we are pleased that our actual Mortality Rate compares favorably with predicted mortality rates, careful analysis of data indicates one range specifically that falls below predicted mortality rates. In reviewing cases of severe trauma we find that patients were stabilized and released from acute care level to home or to receive appropriate therapies. Our own records indicate that 1,187 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Our own records also indicate that of the 76 Medicare patients who died within 30 days of admission, 16 were still alive at the time of discharge. It is impossible to analyze the 16 patients dying after discharge as information concerning death after discharge is not included in the patient's medical record. We will continue to review all death cases at Manitowoc Memorial Hospital as a quality assurance directive in a continuing effort to provide the highest quality care to our patients.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Ray Wimmer, Jr.
President



Memorial Hospital
of Burlington

COMMENTS ON THE HCFA MORTALITY DATA

Data Verification

The data used by HCFA indicate that a total of 123 Medicare patients admitted to Memorial Hospital died within 30 days of admission. Of these, 95 died while still a patient of the hospital, while 28 died after discharge. Our own records indicate that 1,262 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at Memorial Hospital is correct. Our own records also indicate that of the 95 Medicare patients who died within 30 days of admission while still an inpatient, none were still alive at the time of discharge. (NOTE: the hospital should submit to HCFA a corrected copy of the patient listing clearly identifying any patients mistakenly coded as dead at the time of discharge.) It is impossible to determine the percentage of the 28 patients dying after discharge who were in fact alive, as information concerning death after discharge is not included in the patient's medical record.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

In 2 of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. After correcting the errors in the recording of deaths, the number of categories in which the actual mortality rate is outside the range of the predicted mortality rate falls to 2. Several factors may account for this difference.

Unique Services Resulting in Higher than Average Mortality

There is an acute shortage of skilled nursing home beds in Racine County and consequently patients with chronic degenerative conditions (i.e., cancer) are often admitted to the hospital shortly before death.

Results of Preliminary Medicare Record Review

1. Statistics as reported by HCFA do not include information regarding multiple medical diagnoses, severity of illness, cause of death, and patients and/or families request to not initiate life-prolonging measures.

2. Diagnostic Category -

   Renal Disease:

      Renal Disease statistics are skewed and less reliable, due to the small number of cases in this category.

      Of the five patients who died in the hospital, four had multiple medical problems and the fifth had chronic renal disease and at that time was in end-stage renal failure.

   Cancer:

      In more than half of the patients in this category death was the expected outcome at admission. These acutely ill patients required more care than could be rendered at home. Due to the fact that a hospice unit is not readily available, these patients were admitted to the hospital.

      29% of the patients listed died after discharge with the cause of death unknown to the hospital.

3. All the hospital mortalities are reviewed by the Quality Management Committee to determine that the care was appropriate and timely. Specifically, in the review of cancer and renal disease deaths it was determined that the care administered was appropriate in each case and no quality of care issues existed.

HC472J

MEMORIAL HOSPITAL CORPORATION OF BURLINGTON
BURLINGTON, WISCONSIN

Worksheet 1: Analysis of Reporting Errors

Diagnostic Category	Deaths Reported by HCFA		Death Verified by Hospital	
	In-hospital	Post-hospital	In-hospital	Post-hospital
CA -- Cancer	14	7	15	6
CE -- Cerebrovascular Accidents	7	5	7	5
GC -- Gastrointestinal Catastrophes	1	1	1	1
GI -- Gastrointestinal Disease	4	1	4	1
GU -- Urologic Disease	0	1	0	1
GY -- Gynecologic Disease	0	0	0	0
HL -- Low Risk Heart Disease	3	2	3	2
HM -- Severe Chronic Heart Disease	9	0	9	0
HS -- Severe Acute Heart Disease	7	2	8	1
ME -- Metabolic/Electrolyte Disturbances	3	1	3	1
OP -- Orthopedic Disorders	2	0	2	0
PN -- Pulmonary Disease	16	5	16	5
RN -- Renal Disease	5	1	5	1
SE -- Sepsis	2	0	2	0
TR -- Severe Trauma	4	0	4	0
EY -- Ophthalmologic Disease	0	0	0	0
UN -- Other Diagnoses	16	4	16	4
Total -- All Categories	93	30	95	28

WI 73.2

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the indivdual care listing. In-hospital deaths are those patients whose date of discharg is the same as the date of death; post-hospital deaths are those patients whose date of death is afte the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30 days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

HC473J

MHO

Fred Spade

October 26, 1987

Health Care Financing Administraton
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Re: Comments on HCFA Mortality Data

Gentlemen:

The data used by HCFA indicate that a total of 123 Medicare patients admitted to Memorial Hospital at Oconomowoc died within thirty days of admission during calendar year 1986. We were only able to verify that 103 of the reported 123 died while a patient at Memorial Hospital. The other 21 were still alive at the time of discharge (see enclosed list of corrections). It should be noted that the date of death for patient [redacted] should be 4/2/86 and not 4/3/86. It is impossible to determine appropriate information on the 21 patients who may have died following discharge since there is no medical record information on what may have caused the death. It would seem that without such accurate information, the data would be flawed. The HCFA report indicates that the mortality rates were based on a total of 903 cases admitted during that year; whereas, in fact, our records indicate that there were a total of 1319 Medicare admissions in 1986.

A preliminary review of the medical records of the 103 cases where we do have information indicates that the cause of death is not the same as the principal diagnosis in 42 of those cases, which seems to be a rather sizable discrepancy. The co-morbidities were not listed, therefore, it is difficult to evaluate the accuracy of the information. In three of the cases (see attached list) the principal diagnosis in the medical record does not correspond to that shown on the listing which HCFA sent to us.

791 East Summit Avenue, Oconomowoc, Wisconsin 53066 (414) 567-0371

It should be noted that 25% of those deaths occurred on the same day as the patient was admitted to the hospital. Experience tells us that under such circumstances, these patients were critically ill or injured at the time of admission which further underlines the fact that "severity of illness" must be taken into account somehow in evaluating the data.

Yours truly,

MEMORIAL HOSPITAL AT OCONOMOWOC

Fred Spade,
Administrator

FS/ja
Attachments

MEMORIAL HOSPITAL AT OCONOMOWOC
ID NUMBER 520062

CORRECTIONS TO MORTALITY DATA

I. ALIVE AT DISCHARGE

	Patient ID	Date of Discharge	Date of Death
1.	[redacted]	10/11/86	10/31/86
2.	[redacted]	8/31/86	9/12/86
3.	[redacted]	4/25/86	5/09/86
4.	[redacted]	7/03/86	7/05/86
5.	[redacted]	6/11/86	6/18/86
6.	[redacted]	5/23/86	5/24/86
7.	[redacted]	5/07/86	5/11/86
8.	[redacted]	1/18/86	1/20/86
9.	[redacted]	10/30/86	11/07/86
10.	[redacted]	10/23/86	10/29/86
11.	[redacted]	3/24/86	4/03/86
12.	[redacted]	1/28/86	1/31/86
13.	[redacted]	4/25/86	4/28/86
14.	[redacted]	5/20/86	5/30/86
15.	[redacted]	2/18/86	2/19/86
16.	[redacted]	2/1/86	2/14/86
17.	[redacted]	1/03/86	1/28/86
18.	[redacted]	12/08/86	12/18/86
19.	[redacted]	8/30/86	9/17/86
20.	[redacted]	2/11/86	2/28/86
21.	[redacted]	7/23/86	7/31/86

II. PRINCIPAL DIAGNOSIS INCORRECT

	Patient ID	Principal Diagnosis Listed	Principal Diagnosis - Medical Record
1.	[redacted]	1629	0380
2.	[redacted]	49390	4411
3.	[redacted]	4828	03842

MEMORIAL HOSPITAL & HOME

216 SUNSET PLACE
NEILLSVILLE, WISCONSIN 54456
715-743-3101

Glen E. Grady, Administrator

October 15, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

To whom it may concern:

The hospital specific mortality data, as published, has three major flaws that will greatly affect small rural hospitals in general and Memorial Hospital, Neillsville in particular.

1) The pure number of admissions at small rural hospitals in total and by each of the sixteen categories is so small that a single death, regardless of cause, has a great effect on the statistical sample.

2) HCFA used the following categories when adjusting for age: Under 65, 65-69, 70-74, 75-79, 80-84, and above 84. This allows all deaths of residents over 85, regardless of age, to be thrown together and any hospital with a high concentration of deaths of beneficiaries over 89 will be affected at the same rate as a hospital that had several deaths between 85 and 88 and none in the older age category.

3) The third problem is that the data fails to take into account whether or not the patient was admitted from a nursing home.

The first problem, that of small number analysis, is self explanatory. In the one category that our hospital was above the norm, one less death would have put us at the top of the predicted range, but not over the range.

The second problem, a lack of categories in the very old range, is particularly bothersome for us. As people age beyond 84 the likelihood of dying from any cause increases greatly with each passing day. They generally are less active due to a decrease in muscle tone, balance, etc., and are more susceptible to disease of the heart, lungs, and blood.

The statistical likelihood of someone 90 actually living until he or she is 95 is much lower that the likelihood of someone 85 living until they are 90.

Our mortality statistics for the one area for which we are in excess of the expected norm, severe chronic heart disease, show eight of the twelve deaths for beneficiaries in the 85 and older category. Of those eight, two were in excess of 95, two were between 90 and 95, and two were 89. In other words 75% of deaths in that category were 89 or over and 25% of the deaths in that category (85 and over) were over 95. These numbers are extremely statistically significant. For all categories a full 41% of deaths at our hospital for those 85 and over (12 out of 29) were for patients in excess of 89.

The third area, nursing home patients' death, is significant because people in nursing homes are there because of loss of physical function, mental function, or both. We have an attached 176 bed nursing home, where the average age of all deaths for nursing home residents in 1986 was 90. Our nursing home is a skilled care facility so most of the residents are classified as needing 24 hour nursing supervision because of one or several chronic problems. These residents are generally less active than people living independently, already have developed several comorbidities, and are generally more susceptible to severe chronic heart disease. Eleven out of the twelve patients who died in that diagnostic categories were nursing home residents before hospitalization. Some died after being readmitted to the nursing home.

In summary, we feel that because of the lack of an age category breakout after 84 years old, and because of a lack of recognition of whether or not a patient was a nursing home patient before admittance to the hospital, Memorial Hospital has been extremey negatively affected in this data release. We also feel that small rural hospitals in general can easily by negatively affected in such a release because of the much larger effect a single death can have on our hospital specific data.

Sincerely,

Glen E. Grady
Administrator

GEG:jcm

THE MEMORIAL HOSPITAL OF IOWA COUNTY, INC.

October 27, 1987

The Department of Health and Human Services
Health Care Financing Administration
The Administrator
Washington, D.C. 20201

RE: HCFA Mortality Information
Memorial Hospital of Iowa County, Inc.
Hospital ID #520032

At Memorial Hospital of Iowa County, Inc., all of the actual mortality percentages were within HCFA's predicted rates. However, due to concerns regarding the accuracy of HCFA's mortality information and concerns with the purpose for which it may be used after it is published, the following is offered:

Data Verification:

The data used by HCFA indicates that 40 patients of the 301 Medicare patients admitted to Memorial Hospital of Iowa County, Inc. died within 30 days of admission. Of these, 30 died while still a patient of the hospital, while 9 died after discharge. Memorial Hospital of Iowa County, Inc. records indicate discrepancies in the following areas:

1. Total discharges, less transfers to other acute care facilities, for Medicare patients, according to Memorial Hospital of Iowa County, Inc.'s statistics, were more than 460. Thus, overall mortality rate is approximately 9%, and the overall mortality rate while hospitalized is approximately 7%, rather than the indicated 13%.

2. One HCFA recorded mortality was a transfer to a tertiary care center, and therefore should not have been included in the Memorial Hospital of Iowa County, Inc. statistics.

3. Further, in cases where death occurred after hospital discharge, the facility cannot appropriately verify the information.

Statistics Related to Definitions:

Statistics printed are categorized by principal diagnosis. A principal diagnosis is defined by HCFA to be "The condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care".

This principal diagnosis may or may not relate to significant condition(s) which may be predictably a higher risk factor for death than the principal diagnosis. Facilities are further at high risk of problematic interpretation due to the critical necessity of accuracy. An example of this, with statistics based on the principal diagnosis only, is the difficulty with accurately identifying the principal diagnosis and accurately sequencing this in relationship to all diagnoses which may affect the patient's condition and/or predictability of death. An error made in this identification of principal diagnosis and subsequent sequencing, particularly in a small overall number of cases, could significantly impact these statistics.

These statistics, as published, do not adequately address multiple significant medical problems which affect management and severity of the patient's status, or the risk of death. Care in known terminal stage illness is a significant factor, but not considered in these statistics (such as terminal cancer patients, end stage renal disease patients, etc.). No heroic measures had been requested by families in 83% of the cases expiring at Memorial.

No allowance has been made for adjustments for patients over age 85. Thirty percent of the deaths reflected in these statistics were over age 85, and 23 percent were over age 90. Geographic localities with a high percentage of the very elderly will have higher anticipated mortality rates.

Statistics Not Accurate Measure of Quality of Care

Measures should be taken not to definitively relate the quality of care with these mortality statistics, which are based on limited patient factors. These statistics can be best used internally, within a facility, from which to provide another aspect of case review. Published statistics should also include a facility's "success" rate, such as the percentages of patients with heart attacks who survive.

If there are any questions or comments regarding our comments, please contact us.

Yours truly,

Rosellen Crow
Administrator

RC/db

MEMORIAL HOSPITAL OF TAYLOR COUNTY
AND MEMORIAL NURSING HOME
MEDFORD, WISCONSIN 54451
TELEPHONE: 715-748-2600

EUGENE W. ARNETT
PRESIDENT

October 26, 1987

Comments on the HCFA Mortality Data

Data Verification

The data used by HCFA indicate that a total of 38 Medicare patients admitted to Memorial Hospital died within 30 days of admission. Of these, 26 died while still a patient of the hospital, while 12 died after discharge. Our own records indicated that 570 Medicare admissions occurred in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. Our own records also indicate that 12 Medicare patients who died within 30 days of admission were still alive at the time of discharge.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

Interpretive Remarks

In none of the diagnostic categories did the hospital's actual mortality rate fall outside of the range of the predicted mortality rate. After correcting any possible errors in the recording of deaths, the number of categories in which the actual mortality rate is outside the range of the predicted mortality rate remains the same.

Jane Schisz RN

Mercy Hospital
Janesville

1000 Mineral Point Avenue
Janesville, Wisconsin 53545
608 756 6000

October 27, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Washington, D.C. 20201

Dear Doctor Roper:

Mercy Hospital is a licensed 240 bed acute care facility which has served the people of our area since 1895. The patient care mix at Mercy includes many patients with major medical and surgical illnesses. Speciality care in orthopedics and dialysis is also provided to our patients.

The review of the quality of care patients receive at Mercy Hospital is completed in an ongoing manner, not just when mortality data is released. The Joint Commission on Accreditation of Hospitals has continually approved this hospital's Quality Assurance Program and the excellent peer review process that is performed here.

The hospital's specific mortality data reported by H.C.F.A has been reviewed by myself, and all other pertinent personnel. Our percentages are within acceptable ranges as reported by H.C.F.A. in all categories.

We appreciate the opportunity to preview our Hospital Specific data prior to public release and hope this practice will continue.

Sincerely,

Sister M. Michael

Sister M. Michael Berry
Adminstrator

/rs

MERCY MEDICAL CENTER

A MEMBER OF MINISTRY CORPORATION
SISTERS OF THE SORROWFUL MOTHER

JOSEPH P. ROSS
PRESIDENT

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Room 314G
Hubert H. Humphrey Building
200 Independence Avenue South West
Washington, D.C. 20201

Dear Dr. Roper,

Mercy Medical Center places the highest importance on its quality of care. The hospital, working with its Medical Staff and Board of Directors, has developed a Quality Assurance Program which meets all of the standards of the Joint Commission on Accreditation of Healthcare Organizations. The Quality Assurance Program provides for continual monitoring and evaluation of patient care services. This program includes a review of all hospital deaths regardless of the source of payment.

Following receipt of the HCFA Mortality Study, Mercy Medical Center conducted an evaluation of the data, comparing it with the results of our own review of hospital deaths and available medical records information.

The data used by HCFA indicate that a total of 230 of the 2,197 Medicare patients in the study who were admitted to Mercy Medical Center during 1986 expired within 30 days of admission. Of these, approximately 27% expired after discharge. The calculated mortality rate of 10% for Mercy Medical Center was at the low end of HCFA's "Predicted Mortality Range" of 10 to 16%.

Mercy Medical Center's records indicate a substantially higher number of admissions of Medicare patients, presumably reflecting multiple admissions of individuals. Hospital medical records do not contain information related to deaths occuring after patients are discharged. Therefore, it is impossible for the hospital to verify whether or not any such patients were in fact alive within the time limitation of this study or whether the actual cause of death was related to the reason for hospitalization.

As a result of this evaluation, Mercy Medical Center is concerned that, when the HCFA Mortality Rates are published, more emphasis may be placed on the specific numbers that is actually warranted. This may be more likely if appropriate and understandable information explaining the study design and limitations is not provided.

631 HAZEL STREET
POST OFFICE BOX 1100
OSHKOSH, WISCONSIN 54902
414-236-2000

There are a number of factors that lead us to this review, including:

a. The study has limitations which may or may not have incorporated all significant factors, including the acuity of patients admitted by individual hospitals. In addition, this is the first published study using the metholology, therefore the validity and reliability of this study methodology has not been demonstrated.

b. Several diagnostic categories (especially the low-risk categories) are subject to misinterpretation unless the reader is aware that, in the current environment, few patients are admitted for such care. Rather, they are treated in an outpatient setting. This helps to explain why a low-risk category, such as ophthalmologic disease, can have an extremely broad "Predicted Mortality Range" and actual values.

c. Comparison of specific rates between institutions, especially if the differences are small, will probably not reflect or detect any significant difference in the quality of care provided. A number of other factors could reasonably account for such differences.

In summary, Mercy Medical Center believes that this mortality information may serve as a broad indicator and, subsequently, as the basis for further evaluation by the hospital and its medical staff. However, in its current state, this information is not a direct and conclusive indication of actual institutional performance or quality. Moreover, the study may be subject to misinterpretation regarding the quality and outcomes of medical care.

Sincerely,

Joseph P. Ross
President

JPR/sh

MILWAUKEE COUNTY
medical complex

8700 West Wisconsin Avenue Milwaukee, WI 53226 414-257-5936

William I. Jenkins, FACHE
Hospital Administrator

October 28, 1987 Medicare Hospital I.D. Number - 520174

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The Milwaukee County Medical Complex is a major teaching hospital providing tertiary referral care in Southeastern Wisconsin. For critically ill or seriously injured persons, the Hospital serves the entire state, the upper peninsula of Michigan, and Northern Illinois through its Flight for Life Helicopter/Emergency Medical Aero-Evac System. Further, the Hospital serves as the base for Milwaukee County's Paramedic System, with its communication center providing physician direction to Paramedic Services in the field. The incorporation of this information into the body of this report is essential in understanding our response to HCFA to the publication of 1986 Mortality Data and our concerns of any interpretation which might imply that this data is somehow relevant to quality of care delivered at the Milwaukee County Medical Complex

MCMC notes that its experienced mortality is within the predicted range of expected mortality in 15 of the 16 Diagnostic Categories established in the HCFA model. In one of those sixteen Diagnostic Categories used by HCFA, Severe Acute Heart Disease, Milwaukee County Medical Complex's actual mortality rate falls slightly outside of the range predicted by the model utilized by HCFA to calculate hospital mortality rates and ranges.

All 46 deaths listed in the Severe Acute Heart Disease category were reviewed by physicians at MCMC. The following information is a summary of this review:

1. Of these 46 patients, Milwaukee County's paramedic system transported 10 patients to MCMC after restoring cardiac and respiratory function in the field. Each of these subsequently expired. Two of the 10 patients had been treated and discharged from another hospital prior to their admission to MCMC via paramedics. The clinical condition of these 10 patients (who are commonly referred to as pulseless, non breathers) at the time of arrival at the Hospital, made survival highly improbable. Using the review criteria suggested by HCFA the physicians identified death as the expected outcome.

2. Transfers of critically ill patients from other facilities account for another 10 of the 46 deaths, all of which were related to dissecting aortic aneurysms or acute myocardial infarctions with complications. Two of the patients who were transferred to MCMC had been treated initially at two other hospitals. Review of these cases by physicians revealed that death was a significant possibility at the time of transfer to MCMC.

3. A total of 4 patients expired following discharge from the Hospital. One of these patients, previously identified above as pulseless, non breather, remained comatose and in a vegetative state and was transferred to another hospital at their request, where he subsequently died. Another patient, 95 years of age, died at home fifteen days after discharge with chronic, unresponsive congestive heart failure and dementia. Two patients with coronary artery disease, one of whom had been discharged stable following care for a myocardial infarction, died suddenly at home, presumably of cardiac arrhythmia.

4. Of the remaining 23 patients, two had ruptured abdominal aneurysms and the remaining twenty-one had acute myocardial infarctions. Once again, using the review criteria suggested by HCFA 19 of these deaths were a significant possibility at the time of admission. For 3, death was an expected outcome. Another of these deaths was attributed to a number of complicating conditions not considered in the HCFA model.

Of the total number of patients involved, 32 were over the age of 70 and of these 32, twelve patients were over the age of 80.

We view the variables used by HCFA as being intended to serve as surrogates for the determination of and adjustment for severity, providing the basis by which HCFA calculated the range of expected mortality. We appreciate that HCFA is restricted to developing methodologies based upon information contained in individual patient billing forms submitted to the Medicare program for reimbursement. Accordingly we must point out that such data cannot account for differences between hospitals, specifically differences related to the severity of illness of patients who are referred to

teaching, tertiary care, referral hospitals such as the Milwaukee County Medical Complex.

For example, in the category of Severe Acute Heart Disease, if severity factors, in addition to those used by HCFA, descriptive of this Hospital's programs and role as noted earlier had been used, the predicted range of mortality would have been significantly shifted upwards. Since we are not able to recalculate the range of predicted mortality, we have recalculated our mortality experience eliminating the 19 patients whose deaths were expected at the time of their admission to the Milwaukee County Medical Complex. The recalculated rate of 32% mortality is at the lower range of the mortality predicted by the model used by HCFA in its analysis of 1986 mortality.

As stated earlier in this report, we are deeply concerned that the media and the general public will view these data as indicative of the quality of services provided not only at the Milwaukee County Medical Complex, but at other hospitals as well. We believe that because of the severe limitations of the HCFA methodology in predicting expected mortality rates, the data would be more appropriately viewed as defining, in a rather limited way, the severity of illness for patients admitted to a particular hospital in the 16 diagnostic categories of patients. We support the concept that the public is entitled to valid and reliable information about the quality of care delivered by health care providers, in this instance hospitals. We strongly disagree that the publication of these predicted mortality rates by HCFA achieves that goal.

Sincerely,

William I. Jenkins, FACHE
Hospital Administrator

WLJ:RRB:sh

MOUNT SINAI MEDICAL CENTER

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

To Whom It May Concern:

The purpose of this letter is to present our comments on Mount Sinai Medical Center's HCFA mortality statistics which were released to us for review on September 21, 1987. The comments will address:

* A review of Mount Sinai's HCFA mortality rates and the factors contributing to Mount Sinai's exceeding the sepsis predicted mortality range by 1%;
* The use of mortality data;
* The HCFA model; and
* Errors in HCFA's mortality data for Mount Sinai.

Review of Mount Sinai's HCFA Mortality Results

Attachment A provides a profile of the published HCFA mortality data for Mount Sinai Medical Center and contains an adjustment (allowed by HCFA) to that data for patients discharged to another hospital and a further adjustment (recommended by Mount Sinai) for deaths associated with our hospice unit. The left-hand portion of the table shows that Mount Sinai was within the predicted range of mortality rates for all diagnostic categories except sepsis where it was one percentage point over, and further shows that Mount Sinai's actual mortality rate was at or below the HCFA midrange mortality rate for all causes and for ten of the sixteen diagnostic categories. Also, please note that our medical record indicates that one patient, that was discharged within 30 days of admission to another short term general acute hospital, was erroneously counted as one of Mount Sinai's cases and deaths. This patient was removed from cases and deaths for all causes and from the HL-Low Risk Heart Disease category as shown in the middle portion of Attachment A.

Mount Sinai Medical Center is a 410 bed community teaching hospital (affiliated with both the University of Wisconsin Medical School in Madison and the Medical College of Wisconsin in Milwaukee) and offers a broad range of primary, secondary, and tertiary services and programs. Mount Sinai operates geriatrics and hospice programs. As a result of its medical school affiliations and these specialized programs Mount Sinai has attracted a substantial number of frail elderly, terminally ill, Medicare patients from its service area. The HCFA model's nonrecognition of total Medicare cases and especially the hospice and frail elderly patients has contributed to its calculation of higher mortality rates in the following instances:

950 NORTH 12TH STREET, P.O. BOX 342, MILWAUKEE, WISCONSIN 53201-0342, (414) 289-8200

1. Although Mount Sinai treated a total of 3,839 Medicare inpatients in calendar year 1986 the HCFA model only recognized 2,434 cases since it did not include readmissions. Therefore, HCFA's lower case number resulted in the calculation of higher overall and diagnostic specific mortality rates;

2. The HCFA model's nonadjustment for hospice patients also resulted in inflated overall and diagnostic specific mortality rates as shown in the right side of the table in Attachment A. If HCFA's model had excluded these hospice patients from its calculations then Mount Sinai's cancer mortality rate would have dropped from 30% to 15%; and

3. The HCFA model's nonadjustment for patient severity (as exemplified by the following factors) contributed to Mount Sinai exceeding the sepsis mortality rate range by 1%:

    a. All 39 of the sepsis (infection) cases (including the 21 mortality cases) were admitted to Mount Sinai with an infection already established. None of these cases incurred nosocomial infections subsequent to their admission to Mount Sinai;

    b. Of the 21 sepsis patients who died all had a minimum of 4 or more other medical complications (an average of 7.6 co-morbidities), and only 6 died of sepsis as the principal cause of death;

    c. The 21 sepsis mortality cases had ages ranging from 61 to 98 with an average age of 78 and median age of 75;

    d. The 21 sepsis patients who died had previous admissions to the Medical Center (averaging at least 1.6 admissions) which were not accounted for thus resulting in the calculation of a higher mortality rate; and

    e. Attachment A shows that the 21 sepsis mortality cases included two hospice patients which if subtracted would have decreased Mount Sinai's sepsis mortality rate from 54% to 51% which is within HCFA's predicted mortality range.

Comments on the Use of Mortality Data

Mount Sinai routinely reviews internal mortality cases as part of its quality assurance program; however, mortality data is only one of several factors that are used to measure and monitor the overall quality of patient care delivered at Mount Sinai.

Mortality data are most appropriately used in guiding peer review. The maintenance of the highest quality health care is always the goal at Mount Sinai, and mortality data, taken alone, are not enough to assure that level of quality. It is essential that this be kept in mind when the data are put to any other use, particularly in making comparisons between hospitals, which may well have dissimilar characteristics affecting the data.

Comments on HCFA Model

Although there has been considerable improvement in the development of the current HCFA model for determining actual mortality rates and predicting mortality rate ranges, the model still contains a number of serious limitations that need to be considered when reviewing and interpreting the data from the model:

1. As mentioned previously the model does not include measures of severity (i.e., how ill the patient was at the time of admission), so hospitals like Mount Sinai which treat unusually large numbers of severely ill patients may have higher than predicted mortality rates;

2. As also mentioned above the model also does not take into account Mount Sinai's number of Medicare patient readmissions during 1986 which resulted from its treatment of a large share of severely ill patients. HCFA's exclusion of these Medicare readmissions has resulted in a higher mortality rate; and

3. The model allocates as many as 40% of total mortality cases to an "All Other" category because it is unable to assign them to specific diagnostic categories. This has shortchanged the 16 diagnostic categories of these cases and again has unneccessarily increased the mortality rates as a result.

Errors in HCFA Mortality Data

Mount Sinai staff detected the following errors in reviewing HCFA's case mortality data:

* Six cases listed reveal a discrepancy between the actual date of death and the date of death reported by HCFA; and

* One patient was counted twice [redacted] and [redacted]

Although these errors do not appreciably alter the mortality results they do raise a concern regarding the overall validity of the data used by HCFA. Mount Sinai staff were not able to verify the accuracy of the total number of overall and diagnosis specific HCFA Medicare cases for Mount Sinai since HCFA did not release the detailed methodology used to calculate its numbers.

In closing this letter I would like to first commend HCFA for giving our hospital the opportunity to review and comment on the mortality data before it is publicly released in December. I would also like to commend HCFA for its effort in developing a more sophisticated model for calculating actual mortality rates and predicting a mortality rate range. In contrast with last year in which HCFA determined an overall patient actual mortality rate and a single value predicted mortality rate this year's model was more sophisticated in offering the following features:

* It offers a case mix approach to determining actual mortality rates by calculating mortality rates within 15 specific diagnostic categories;

* The model provides estimates of the relationship between each of the five patient characteristics included in the model (patient's age, sex, prior hospitalizations, tranfer status, and concurrent illnesses) and the risk of death to predict mortality rates for different categories of patients; and

* The predicted mortality rates are stated as a range or "predicted interval" to allow for the fact that the predictions are subject to error.

Our Medical Center supports the publication of hospital-specific mortality rates to enable consumers to have additional information with which to make informed choices about where to seek health care. Nevertheless it is essential that the public understand the purpose and limitations of the soon to be published HCFA mortality data, the limitations of the model used to determine and predict mortality rates, the errors associated with the data regarding our hospital's patients, and specific qualifications which should be kept in mind when interpreting the results of the published data. Mount Sinai therefore supports HCFA's promise to publish our comments along with the publication of our hospital specific mortality data.

I would like to thank you for your review and consideration of our comments. Please do not hesitate to call me if you have any follow up questions to the comments submitted prior to your publication of the data and our comments in December.

Sincerely,

Dennis T. Rakowski
Acting President

Enclosure

ATTACHMENT A

ANALYSIS AND CORRECTION OF HCFA DRG MORTALITY STATISTICS FOR MOUNT SINAI MEDICAL CENTER CY 86

Causes	-------Hospital Data as Reported by HCFA-------- HCFA # Cases	HCFA # Deaths	HCFA Mortality Rate	HCFA Midrange Mortality Rate	HCFA Range of Mortality Rates	* Adjustments for MSMC Pt Disch'd to Other Hospital (Erroneously Included by HCFA in MSMC Mortality Statistics * Pts Disch'd To Other Hospital	Adj # Cases	Adj # Deaths	Adj Mortality Rate	* Subtraction of Hospice Patients From Adjusted MSMC Statistics To Show Effect Of Hospice Program on MSMC Mortality Rates * Hospice # Pts	Readj # Cases	Readj # Deaths	Readj Mortality Rate
All Causes	2434	323	13%	13%	10-16%	1	2,433	322	13%	50	2,383	272	11%
CA-Cancer	200	59	30%	29%	20-37%	0	200	59	30%	34	166	25	15%
CE-CVA	66	22 (1)	33%	29%	17-40%	0	66	22	33%	0	66	22	33%
EY-Ophthalmologic	9	1	11%	40%	0-80%	0	9	1	11%	0	9	1	11%
GC-GI Catastrophes	45	12	27%	22%	9-34%	0	45	12	27%	1	44	11	25%
GI-GI Disease	173	8	5%	7%	3-11%	0	173	8	5%	0	173	8	5%
GU-Urology	129	7	5%	8%	2-13%	0	129	7	5%	0	129	7	5%
GY-Gynecology	12	0	0%	47%	0-93%	0	12	0	0%	0	12	0	0%
HL-Low Risk Heart Disease	352	18	5%	6%	3-8%	1	351	17	5%	0	351	17	5%
HM-Severe Chronic Health Disease	145	27	19%	23%	16-30%	0	145	27	19%	2	143	25	17%
HS-Severe Acute Heart Disease	91	24	26%	39%	28-50%	0	91	24	26%	0	91	24	26%
ME-Metabolic/Electrolyte	54	12	22%	24%	11-36%	0	54	12	22%	6	48	6	13%
OP-Orthopedics	87	3	3%	5%	0-9%	0	87	3	3%	0	87	3	3%
PN-Pulmonary	198	50	25%	22%	15-29%	0	198	50	25%	3	195	47	24%
RN-Renal Disease	18	4	22%	28%	6-49%	0	18	4	22%	0	18	4	22%
SE-Sepsis	39	21	54%	37%	20-53%	0	39	21	54%	2	37	19	51%
TR-Severe Trauma	50	7	14%	13%	4-22%	0	50	7	14%	0	50	7	14%
UK-Unknown	766	48	6%	?	?	0	766	48	6%	2	764	46	6%

(1) One patient appeared twice on HCFA's list of deaths for this category; therefore, the number of deaths should be 21.

NOTES
"Adjusted" = HCFA data minus patient discharged to another hospital
"Readjusted" = "Adjusted" data minus hospice

WI 87.4

Comments
HCFA Mortality Data
New Berlin Memorial Hospital

INTRODUCTORY COMMENTS

New Berlin Memorial Hospital is a 126-bed (licensed) acute care hospital located in New Berlin, Wisconsin. The hospital is a member of the Waukesha Hospital System, Inc., a non-profit, two-hospital system located in--and dedicated to--Waukesha County.

The hospital is a community healthcare facility providing both inpatient and an increasing amount of outpatient services to the New Berlin area. In addition to direct patient care, the hospital offers a variety of health education and wellness activities for the community. Older adults especially benefit from services such as Lifeline, MealMobile, health screenings and other programs.

The hospital has a voluntary governing board comprised primarily of community representatives. The Board of Directors meets bi-monthly.

The hospital's quality assurance program encompasses every aspect of patient care. All deaths that occur at New Berlin Memorial Hospital are reviewed to determine if any quality assurance issues were involved. Peer review is an important part of this process. Each case is scrutinized by a physician and appropriate nursing personnel to assess whether hospital quality-of-care standards were met. The results of the quality assurance and peer review process are reported on a regular basis to the hospital's board.

HCFA DATA

Preliminary verification review of the HCFA-released mortality data shows some variation in the actual number of cases reported. These variations do not significantly alter the mortality rates reported.

INTERPRETIVE REMARKS

It is relevant to note that in each of the sixteen categories used by HCFA, New Berlin Memorial Hospital had fewer than one hundred cases reported. In ten of the sixteen, there were fewer than 30 cases reported. When a diagnostic category contains only a few reported cases, one death can represent a mortality rate of 20-30%, or more. In some instances, this causes a significant distortion of the mortality rate figure. Such is the case at New Berlin Memorial, where in some categories the total mortality rate reflects one, two or three deaths.

Despite this, New Berlin Memorial Hospital's mortality rates fall well within the predicted mortality ranges calculated for the facility. A review of medical records indicates that the deaths which did occur could be anticipated from the disease course present at the time of admission. Records also indicate that the individuals who died after discharge from the hospital were placed in an appropriate setting for their degree of illness (e.g. returned to or placed in a nursing home; or discharged to home health care or hospice care).

CLOSING COMMENTS

It is important to remember that the HCFA data represents mortality data for Medicare patients only, which includes patients over the age of 65 (the largest proportion of Medicare patients), and individuals who are totally disabled by a chronic illness. This data, therefore, represents just one facet of quality of care for individuals entering the facility. Individuals of all age groups are encouraged to use the personal and professional resources available to them--including New Berlin Memorial Hospital--for assistance in making informed choices regarding hospital services.

Northwest General Hospital

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Heatlh and Human Services
Washington, D.C. 20201

Dear Dr. Roper:

Thank you for allowing me to make comments about the mortality data that will be released in December of 1987.

First, I want to say that Northwest General Hospital provides high quality health care services. We are always striving to improve care to our patients. The Medical Staff, Board of Directors, employees and management are committed to insuring quality. The Review of the HCFA data proved to be an excellent exercise to make sure from external sources that high quality and appropriate care was provided to these patients.

Secondly, I would like to say that the data is accurate for Northwest General Hospital. In some instances a good case for an alternative "cause" of death could be made. These causes appear as co-morbidities on the medical record.

Thirdly, I wish to point out that none of these records were requested for additional review by the Wisconsin PRO.

The following are some specific comments about selected diagnoses:

1. "Cancer" is the only category under which Northwest General exceeded the range of predicted mortality.

   There were six cases, all of which were stage C or stage D cancers. One patient requested that he not even know the primary site of the cancer. This patient wanted to die at home, without treatment, which did occur. Home health care managed the patient for the most part. Inpatient and outpatient treatment occurred to relieve pain and discomfort through paracentesis.

   Another of the patients had multiple system problems, any one of which could have been the cause of death.

   A third patient was never strong enough to tolerate either surgical intervention or chemotherapy.

A member of the American Osteopathic Hospital Association and the Wisconsin Hospital Association
5310 West Capitol Drive, Milwaukee, Wisconsin 53216, 414-447-8543

The fourth patient was found to have oat cell cancer in the lungs.

The fifth patient was found to have adenocarcinoma upon surgical exploration of the abdomen with liver and peritenoneum involvement.

The sixth patient was treated surgically for esophageal adenocarcinoma (with positive nodes). The patient did not respond to the radical nature of the surgery.

Upon review, only the final case was one where prolonging life was an issue, which is why that surgical intervention was made.

2. While the mortality statistics for metabolic/electrolyte disturbances for Northwest General were within the predicted range, we specifically reviewed the three cases.

The first patient was admitted with stage D cancer, severely dehydrated from a nursing home. The patient, physician and family considered the cancer to be terminal.

The second patient was admitted during a period of extreme hot weather. The patient evidently had not eaten or drank anything for about a week before the admission. The patient was not able to tolerate this type of dehydration at age 90.

The final patient in this category was admitted in a hyopglycemia coma. This patient was 96 years old with stage C breast cancer. After an appropriate course of therapy, attempts were made to transfer this patient, first to a Hospice and next to a nursing home.

3. The final category to which I will respond is that of gastrointestinal catastrophe. The five mortality cases were specifically reviewed.

The first patient was an 87 year old with a small bowel obstruction. The patient had multiple co-morbidities and died due to renal failure and congestive heart failure.

The second patient was admitted for a bowel obstruction, but prior to surgery suffered a myocardial infarction. The patient also had a urinary tract infection at admission.

The third patient was an 87 year old admitted from a nursing home with hemorrhagic gastritis. The patient was discharged in an improved condition back to the nursing home.

The fourth patient was a 61 year old probable substance abuser with end stage liver disease. This patient had numerous admissions for treatment of the chronic problem that had reached an acute stage.

The final patient was an 86 year old who also had end stage liver disease.

While this data is certainly a tool for hospitals and medical staffs to use for continued evaluation of care, it is important to make the point that the use or comparison of this data alone among hospitals will mislead the various publics. I appreciate your awareness of this fact as a physician and the HCFA Administrator.

I look forward to the day where real comparable measures of quality are developed so that the American Health Care System can retain its position as the world's finest.

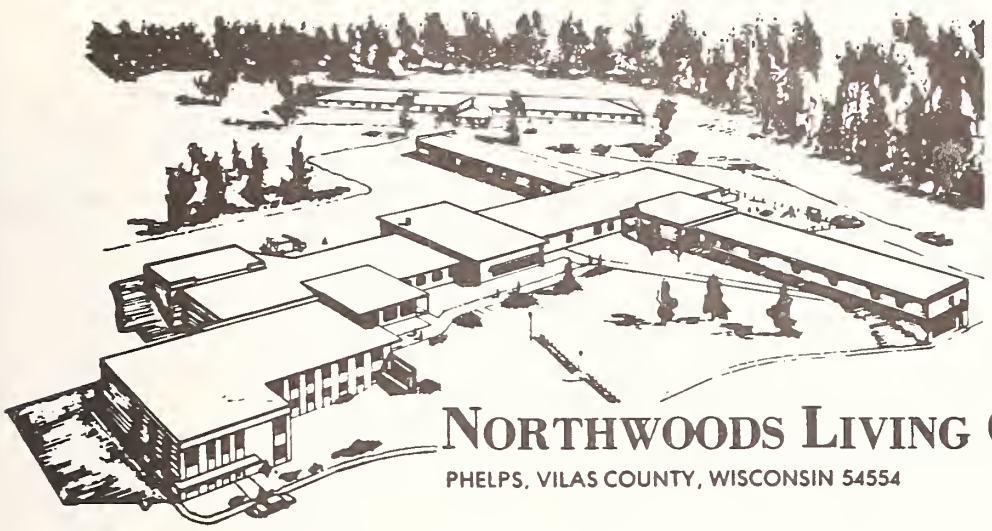
Sincerely,

NORTHWEST GENERAL HOSPITAL

Robert G. Polahar

ROBERT G. POLAHAR
ADMINISTRATOR

RGP:cjo



NORTHWOODS HOSPITAL

CLINIC - PHARMACY

LILLIAN E. KERR
NURSING HOME

DEMMER DAY CARE CENTER

SENIOR CITIZENS
NORTHWOODS VILLAGE

NORTHWOODS LIVING CARE CENTER

PHELPS, VILAS COUNTY, WISCONSIN 54554 715-545-2313

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P. O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Northwoods Hospital (52-1020) wishes to make the following comments regarding the release of mortality data for the nations hospitals and most specifically for Northwoods Hospital.

The reader should be aware that statistical sampling and statistical representation assumes an adequate population in order to draw a valid statistical conclusion. In the case of Northwoods Hospital, it is impossible to produce an appropriate population size because of the size of the facility. The smallness of Northwoods Hospital causes a large probablility range. The reader will note the large probability ranges based on the data summary noted.

The reader should further be aware that Northwoods Hospital has an 81 bed nursing home used by elderly residents, and two elderly housing units comprised of 32 beds. These persons prior to their death, will be transferred into the hospital, which may impact on mortality rates.

Dr. Roper, your help in clarifying these special facility considerations will aid the reader in best understanding these statistics.

Sincerely,

Curtis A. Johnson
Administrator

CAJ:mcp

VALLEY VIEW MEDICAL CENTER

901 Reed Street
Plymouth, Wisconsin 53073
Telephone (414) 893-1771

October 29, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Mr. Roper:

This letter is in direct response to data provided to us concerning the mortality statistics of Valley View Medical Center. The data used by HCFA indicate that a total of 47 Medicare patients were admitted to Valley View Medical Center who died within thirty days of that admission. Of these, 25 died while still a patient of our facility and 22 died after discharge. HCFC data indicates 292 Medicare cases for this facility in 1986, while our records indicate 470 Medicare discharges with this discrepancy presumably due to multiple admissions of individual patients. Of this 470, the overall mortality was 6%. We are happy to see that in all but one diagnostic category, this facility's actual mortality data rate falls within the range of predicted mortality rates given by HCFA. In two of the categories, our actual rate is near the top of the predicted range. All three of these categories are high risk diagnostic categories. Of the 22 patients who died within 30 days following discharge, all of them did so while receiving care in the skilled nursing facility, whether within our own buildings or at another one located close by. All of these patients had chronic conditions and multiple diagnoses as well as an average age of over 80 years old. In the area of cerebral vascular accidents, it should be understood that we are only talking about 12 cases, only four of which actually died within the Medical Center, and the rest expired within a nursing home.

Although we strongly believe that the consumer has a legitimate interest in obtaining useful and reliable information on the providers of health care in their area, it should be noted that utilization of this data by providers is not new in that our facility has produced this data internally and utilized it in the quality assurance and peer review process. We feel very strongly that this type of data can really do no more than identify potential areas which need evaluation. This type of model is useful as a screen but, as with any model, has certain limitations which we will address further on in this letter. We will use this, as we use all mortality data, to determine if there needs to be further evaluation of this area and to take a look at whether these patients have had unusually complex problems or other characteristics not recognized by your model. We will utilize this to focus our quality assurance and peer review efforts

as we have done with other mortality data. We feel that true quality can only be evaluated by peer review and not by simplistic statistical comparisons. If quality problems do exist, we can assure you that corrective action has been, and always will be, taken swiftly. We agree that the utilization of this data should be taken seriously and that the commitment of our Medical Center to quality must be maintained in our attempt to put this data into a meaningful context. We feel it provides us with an actual percentage of people who died, but we really need to look at the percentage of people who died because of the care they received.

Valley View Medical Center does have some special programs which attract patient populations which experience a high rate of mortality. We are also the only hospital in the area with an attached 60-bed skilled nursing facility and 32 retirement apartments. Because of our attached 60-bed skilled nursing facility, we get an inordinate amount of long-term care patients who have had cerebral vascular accidents. Because of our close relationship with the nursing home, we are able to care for these people for a longer period of time in the nursing home and thus we receive them at the hospital in more advanced stages of their illness. Under pulmonary disease, we see again many of these people coming from our area nursing homes and only five of them actually did expire due to pulmonary disease within our facility. The average age of these patients was 79 years old. Under severe chronic heart disease, out of these sixteen, only seven of these patients actually expired within our facility due to severe chronic heart disease. We do have a licensed Hospice unit in the Medical Center. Thus, our Hospice, both the inpatient and outpatient portions, puts us in somewhat of a "Catch 22" situation. We attract many terminally ill patients who seek out the quality services we provide and thus increase the amount of people who die within our facility or within thirty days of discharge for those who choose to use the outpatient Hospice program. We are also the only hospital in the area with swing beds. These patients usually stay 45 days or more after the acute phase. These are considered inpatients and are still counted on our statistics as opposed to being not counted if they die after 30 days post discharge. Our case mix reflects an increased level of intensity with us being listed as ranking 26th out of over 140 hospitals in Wisconsin according to the Federal Regulations.

In evaluating the data that you provided to us, we took a very close look at the model that you utilized to analyze our statistics. We feel the model you developed does measure the relationship between a limited number of patient characteristics and the risk of death. However, we feel that at best, it offers only crude estimates of the expected risk of death. This model, as your agency has admitted, has not been statistically validated and we do not know whether the factors you have included do significantly influence the risk of death. We do know that the model fails to consider a wide range of factors that can have a significant impact on mortality such as the actual cause of death, the patients' general health status, the stage of the patients' illness upon admission, psychological conditions, and family support. We would also very much like to see some sort of measure of severity at the time of admission and also see the inclusion of more characteristics that would avoid having the model assume that all the

patients are similar or "average" except for the characteristics which you presently use. Our organization also will be looking very closely at whether these ranges should be viewed as an achievable target given the types of services and patients we attract. Each facility's case mix must be taken into consideration if any useful comparisons are to be made.

Overall, I feel that the publishing of this type of data to the public is something that is an indication of a need for the public to have the data available to them to evaluate health care providers in their area. However, it is very clear to us, and I'm sure to you, that continued improvements on your model and your honesty about its limitations need to be a part of this disclosure of this process. We do appreciate the opportunity to not only verify the accuracy of your data, but also to have the opportunity to comment and prepare ourselves for its public disclosure.

Sincerely,

Patrick J. Trotter

Patrick J. Trotter
President
Valley View Medical Center

PJT/jac

REEDSBURG AREA
MEDICAL CENTER

October 20, 1987

Dr. William L. Roper, Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

The hospital specific mortality data, as published, has been reviewed by our staff. In the review of our data (54 deaths) the following results were noted:

1. Data was correct as printed, except the age of three patients was incorrect.

2. All cases recorded had contributing commodities which contributed to their death which the data doesn't present.

3. The use of the principle diagnosis (DRG) is very misleading as to the systems involved in their death, i.e., cancer once used as principle diagnosis cannot be repeated as principle. The presenting problem, such as dehydration, kidney failure, etc., will be used as the principle diagnosis. This resulted in 12 patients with terminal cancer being recorded under other DRGs.

4. The extended care/swing bed program are unique services which will result in higher mortality figures. We experience 9 cases in this service.

5. In examining the deaths occurring within thirty days of discharge, 13 of them occurred in a skilled nursing facility.

In further examination of the data results the following conclusions were reached:

1. The statistical sample and its ranges are inaccurate methods of measurement because of the limited number of admissions and number of cases within each category. One case could put a small hospital in or out of the range.

2. The principle diagnosis is not sufficient evidence to determine cause of death.

3. The age categories do not reflect the proper age groupings of the patients. For example, all deaths of patients 85 and older are grouped together. We experienced approximately 19 out of 54 deaths over the age of 85 (20 of which were over 90). This creates an imbalance in the statistical analysis.

4. With the number of deaths occurring outside the hospital and the insufficient diagnosis of those within the hospital, any analysis dealing with quality, method of care or treatment would be inaccurate and libelous.

5. Over 64% of the patients lived beyond their average life expectancy.

I strongly disagree that the information provided to us and the public is useful in determining quality or results of patient care. To imply that death occurring in individuals over the age 65 may be the results of poor quality or inappropriate care is unfounded in the analysis of data collected. A brief encounter (hospital stay) within one's life after age 65 does not outweigh the lifestyle and environment man created for himself.

Sincerely,

George L. Johnson
Administrator
REEDSBURG MEMORIAL HOSPITAL, INC.

GLJ:jmb

PROVIDER'S RESPONSE TO HCFA MORTALITY DATA

RIVERVIEW HOSPITAL ASSOCIATION

October 21, 1987

Medicare Provider Number: 52-0033

The Riverview Hospital Association is pleased to provide additional information regarding the mortality data released by the Health Care Financing Administration (HCFA) of the Department of Health & Human Services. We believe this data provides evidence of the efforts the Association has made to provide effective and efficient care for our Medicare patients.

Of the 104 deaths identified in the data, our records indicate56 occurred while the Medicare patient was hospitalized at Riverview Hospital and 48 occurred after they had been discharged from our facility. (All deaths were counted if they occurred within 30 days of admission to the facility, regardless of where the patient was at the time they died.) Of the 48 who died after being discharged from our facility, 36 had been transferred to a skilled nursing facility. The remaining twelve patients were discharged directly to their homes.

The Association believes this data reflects our understanding that we as health care providers have a responsibility to assist with the dying process. We believe the care we have shown in insuring that individuals are transferred to appropriate facilities represents our efforts to assist families in providing the proper type of care for their family member. All of the staff at Riverview Hospital work hard to insure that our patients receive the care that is appropriate for the decisions that have been made regarding their medical care. In many instances, this means they remain at the hospital. In others, it means they are transferred to a facility that can more appropriately take care of their medical needs.

Any individual receiving this data who has questions regarding the hospital's response please feel free to contact Daniel J. Hymans, Administrator, Riverview Hospital, 410 Dewey Street, P.O. Box 8080, Wisconsin Rapids, WI 54495-8080.

DJH:gjc

SACRED HEART-SAINT MARY'S
HOSPITALS, INCORPORATED

Medicare Provider #52-0029

216 N. 7th Street - Tomahawk, Wisconsin 54487

A MEMBER OF MINISTRY CORPORATION
SISTERS OF THE SORROWFUL MOTHER

October 5, 1987

Diagnostic Category	Deaths Reported by HCFA: In-hospital	Deaths Reported by HCFA: Post-hospital	Deaths Verified by Hospital*: In-hospital	Deaths Verified by Hospital*: Post-hospital
CA -- Cancer	04	02	04	03 *
CE -- Cerebrovascular Accidents	02	01	02	01
GC -- Gastrointestinal Catastrophes	02	—	02	—
GI -- Gastrointestinal Disease	01	—	01	—
GU -- Urologic Disease	—	01	—	01
GY -- Gynecologic Disease	—	—	—	—
HL -- Low Risk Heart Disease	01	—	01	—
HM -- Severe Chronic Heart Disease	02	01	02	01
HS -- Severe Acute Heart Disease	06	—	06	—
ME -- Metabolic/Electrolyte Disturbances	01	—	01	—
OP -- Orthopedic Disorders	—	—	—	—
PN -- Pulmonary Disease	05	—	05	—
RN -- Renal Disease	—	—	—	—
SE -- Sepsis	01	—	01	—
TR -- Severe Trauma	—	01	—	— *
OP -- Ophthalmalogic Disease	—	—	—	—
UN -- Other Diagnoses	03	02	03	02
Total -- All Categories	28	08	28	08

NOTES: In the Deaths reported by HCFA, tabulate the number of deaths assigned to each diagnostic category on the individual care listing. In-hospital deaths are those patients whose date of discharge is the same as the date of death; post-hospital deaths are those patients whose date of death is after the date of discharge. Verified deaths should include those patients who are known to have died or whose status 30-days after discharge from the hospital cannot be determined. Verified deaths should also exclude patients that the hospital does not believe were ever admitted to the hospital.

COMMENTS ON THE HCFA MORTALITY DATA

* RESULTS OF PRELIMINARY MEDICARE RECORD REVIEW: You have patient ID number (HIC) [redacted] listed under Diagnostic Category as TR (Severe Traumatic), patient died post-hospital discharge with an Actual Mortality Rate of 100%. The chart was reviewed by the attending physician and his findings are that patient was discharged with a principal diagnosis of subcapital fracture, but patient had breast carcinoma with metastasis to the lymph nodes, lungs, liver and bone. She was recovering well from her fracture, and was discharged to the nursing home to be given just supportive care for her carcinoma. The attending physician feels that patient should be classified under CA (Cancer), post-hospital death, which would make the Actual Mortality Rate 50%.

SACRED HEART HOSPITAL
216 NORTH 7TH
TOMAHAWK, WISCONSIN 54487-1496
715-453-2181

SAINT MARY'S HOSPITAL
1044 KABEL AVENUE
RHINELANDER, WISCONSIN 54501-3099
715-369-3311

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

HOSPITAL = 520029 SACRED HEART HOSP OF TOMAHAWK INC TOMAHAWK WI

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	217	17 %	10 TO 21 %
CA - CANCER	14-6	43 %	11 TO 58 %
CE - CEREBROVASCULAR ACCIDENTS	14-3	21 %	11 TO 57 %
GC - GASTROINTESTINAL CATASTROPHES	3-2	67 %	1 TO 81 %
GI - GASTROINTESTINAL DISEASE	27-1	4 %	1 TO 23 %
GU - UROLOGIC DISEASE	7-1	14 %	0 TO 62 %
HL - LOW-RISK HEART DISEASE	21-1	5 %	1 TO 27 %
HM - SEVERE CHRONIC HEART DISEASE	11-3	27 %	6 TO 54 %
HS - SEVERE ACUTE HEART DISEASE	9-6	67 %	15 TO 72 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	4-1	25 %	1 TO 74 %
OP - ORTHOPEDIC DISORDERS	4-0	0 %	0 TO 78 %
PN - PULMONARY DISEASE	30-5	17 %	8 TO 37 %
RN - RENAL DISEASE	3-0	0 %	1 TO 82 %
SE - SEPSIS	3-1	33 %	5 TO 86 %
TR - SEVERE TRAUMA	1-1	100 %	0 TO 99 %
UN.	-5		
	36		

WI 104.1

SAUK PRAIRIE MEMORIAL HOSPITAL
80 FIRST STREET
PRAIRIE DU SAC, WISCONSIN 53578
(608) 643-3311

October 22, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

To whom it may concern:

The hospital specific mortality data, as published, has four major flaws that will greatly affect small rural hospitals in general and Sauk Prairie Memorial Hospital in particular.

1) The pure number of admissions at small rural hospitals in total and by each of the sixteen categories is so small that a single death, regardless of cause, has a great effect on the statistical sample. Can the numbers be statistically significant when, in certain categories one death creates an actual mortality rate of 50%?

2) Discharge status of the patients was not taken into account for those patients who died following discharge. Eleven of the thirty-two deaths at SPMH occurred post-discharge. The majority of these patients were transferred to extended care facilities in a terminal state and death was anticipated and expected.

3) The expected outcome of the admission was also not taken into account. In twenty-two of the thirty-two deaths at SPMH, death was the expected outcome at the time of the patient's admission. Of note is the fact that in nineteen of the thirty-two cases, there is documentation in the medical record that the patient and/or family requested that no heroic measures be taken to prolong life.

4) Swing Bed deaths were included with other in-house deaths. Four of the thirty-two deaths occurred while the patients were in the Swing Bed Program, and in each case the patient was suffering from terminal carcinoma with hospice type care. We feel it is not appropriate to include Swing Bed patients with the Acute patients; a separate category could be established for these patients in order to clarify the type of treament rendered.

In summary, we must stress that mortality has never been directly linked to quality of care and request that HCFA acknowledge the limitations and usefullness of this published data. We agree the raw data can be used as a focus for in-house peer review activities, which has been the practice at SPMH for many years but strongly believe that conclusions cannot be drawn from the statistical information alone, without a detailed chart review.

Sincerely,

Wilbur C. Beach
Administrator

Shawano Community Hospital

309 N. Bartlette Street
Shawano, Wisconsin 54166
Phone 715-526-2111

VHA Wisconsin
Voluntary Hospitals of America/Wisconsin ®

October 19, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: December, 1987, Release of HCFA Hospital Mortality Rates

Dear HCFA:

My concern is that the release of this data implies to the public that it is a measure of quality. These raw statistics, at most, can be used only to identify areas for review where a hospital's cases may fall above or below the predicted range. Only through this type of focused review can true problems be identified and addressed.

Shawano Community Hospital conducts an on-going hospital-wide Quality Assurance program as required by any hospital accredited by the JCAH. Included in this program is a monthly mortality review encompassing ALL types of patients (not only Medicare patients as is the case with the HCFA data) and all causes of death. I feel it is significant to point out that this review is only one of numerous quality reviews that are carried out covering nursing staff, medical staff and all clinical departments.

One important point relative to the numbers in this data release is that they are in need of correction and clarification. Out of 89 deaths reported for Shawano Community Hospital 36 occurred outside of the hospital and after discharge from the last in-hospital admission in these cases.

Shawano Community Hospital has long since completed its regular review of all cases reported in HCFA's latest mortality rates and will continue to do so as part of our commitment to provide the very best quality care in serving our local community and surrounding area.

Sincerely,

Harry Wernecke
Administrator

bh

2629 North 7th Street
Sheboygan, WI 53083
414/457 5033

Sheboygan
Memorial
Medical Center

October 28, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

This letter is in direct response to data provided to us concerning the mortality statistics of Sheboygan Memorial Medical Center. The data used by HCFA indicate that a total of 141 Medicare patients were admitted to Sheboygan Memorial Medical Center who died within thirty days of that admission. Of these 97, or 69%, died while still a patient of our facility and 44, or 31%, died after discharge. HCFA data indicates 1,187 Medicare cases for this facility in 1986, while our records indicate 1,708 Medicare discharges. This discrepancy is presumably due to multiple admissions of individual patients. We were happy to see that in all diagnostic categories, this facility's actual mortality data rate falls within the range of predicted mortality rates given by HCFA. In four of the categories, our actual rate is near the top of the predicted range. All four of these categories are high risk diagnostic categories. We did a random sample and found that the mean age of these patients was 74 years old and was equally distributed between males and females. The mean length of stay was six days and 50% of the patients in the sample were admitted with other known health problems. In only 40% of the cases reviewed was death due to the principal diagnosis assigned by HCFA. For example, two patients were admitted with principal diagnosis of bowel obstruction and bowel infarction respectively. Both patients had metastatic cancer. These patients were included in the gastro-intestinal catastrophe category. 34% of all patients who died were residents of extended care facilities and, for all cases in our sample, death was an expected outcome or a distinct possibility.

Although we strongly believe that the consumer has a legitimate interest in obtaining useful and reliable information on the providers of health care in their area, it should be noted that utilization of this data by providers is not new in that our facility has produced this data internally and utilized it in the quality assurance and peer review process.

We feel very strongly that this type of data can really do no more than identify potential areas which need evaluation. This type of model is useful as a screen but, as with any model, has certain limitations which we will address further on in this letter. We will use this, as we use all mortality data, to determine if there needs to be further evaluation of this area and to take a look at whether these patients have had unusually complex problems or other characteristics not recognized by your model. We will utilize this to focus our quality assurance and peer review efforts as we have done with other mortality data. We feel that true quality can only be evaluated by peer review and not by simplistic statistical comparisons. If quality problems do exist, we can assure you that corrective action has been, and always will be, taken swiftly. We agree that the utilization of this data should be taken seriously and that the commitment of our medical center to quality must be maintained in our attempt to put this data into a meaningful context. We feel it provides us with an actual percentage of people who died, but we really need to look at the percentage of people who died because of the care they received.

Memorial Medical Center does have some special programs which attract some patient populations which experience a high rate of mortality. We were the first ones to establish a comprehensive cancer services unit (Agape) within our organization and are the only licensed Hospice unit in the city of Sheboygan. Thus our Hospice, both the inpatient and outpatient portions, puts us in somewhat of a "Catch 22" situation. We attract many terminally ill patients who seek out the quality services we provide and thus increase the amount of people who die within our facility or within thirty days of discharge for those who choose to use the outpatient Hospice program.

In evaluating the data that you provided to us, we took a very close look at the model that you utilized to analyze our statistics. We feel the model you developed does measure the relationship between a limited number of patient characteristics and the risk of death. However, we feel that at best it offers only crude estimates of the expected risk of death. This model, as your agency has admitted, has not been statistically validated and we do not know whether the factors you have included do significantly influence the risk of death. We do know that the model fails to consider a wide range of factors that can have a significant impact on mortality such as the actual cause of death, the patients' general health status, the stage of the patients' illness upon admission, psychological conditions, and family support. We would also very much like to see some sort of measure of severity at the time of admission and also see the inclusion of more characteristics that would avoid having the model assume that all the patients are similar or "average" except for the characteristics which you presently use. Our organization also will be looking very closely at whether these ranges should be viewed as an achievable target given the types of services and patients we attract. Each facility's case mix must be taken into consideration if any useful comparisons are to be made.

Overall, I feel that the publishing of this type of data to the public is something that is an indication of a need for the public to have the data available to them to evaluate health care providers in their area. However, it is very clear to us, and I'm sure to you, that continued improvements on your model and your honesty about its limitations need to be a part of this disclosure of this process. We do appreciate the opportunity to not only verify the accuracy of your data, but also to have the opportunity to comment and prepare ourselves for its public disclosure.

Sincerely,

Patrick J. Trotter
President
Sheboygan Memorial Medical Center

PJT:mlg

Southwest
Health Center

October 28, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

RE: HCFA Mortality Data

TO WHOM IT MAY CONCERN:

The data used by HCFA indicates that a total of 46 Medicare patients admitted to Southwest Health Center died within 30 days of admission. Of these, 34 died while still a patient in the hospital, and 12 died following discharge. Our own records indicate that 460 Medicare admissions occurred in 1986. Presumably, the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients, as reported by HCFA as treated at Southwest Health Center, is correct. Our own records also indicate that of the 36 Medicare patients who died within 30 days of admission while still an inpatient, 424 were still alive at the time of discharge.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

In none of the diagnostic categories does Southwest Health Center's actual mortality rate fall outside of the range of the predicted mortality rate. After correcting the error in the recording of deaths, the number of categories in which the actual mortality rate is outside the range of the predicted mortality rate remains unchanged.

All information from HCFA was verified with one exception. The expiration date of patient [redacted] was not able to be verified after checking our own medical records, the physician's office, Grant County Register of Deeds, and a list entitled, "1986 Wisconsin Deaths by County of Occurrence". In view of the above, our actual mortality rate for HS would be 47% rather than 53%. Also, two patients would have died within 24 hours of discharge, rather than the three that are listed.

Southwest
Health Center, Inc.
Platteville/Cuba City
1100 Fifth Ave.
Platteville, WI 53818
608 348 2331
808 S. Washington St.
Cuba City, WI 53807
608 744 2161

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

Southwest
Health Center

In conclusion, I would only emphasize what every hospital knows, and that is that this type of data, in itself, is no meausre of quality. It is helpful in identifying areas of concern and questions, but not as an end all.

For the small hospital these types of numbers are of little value because one death alone will affect percentages by as much as 10 to 20 points.

Sincerely,

Kenneth W. Creswick
President

KWC/akk

ST. AGNES HOSPITAL

October 23, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Having reviewed the mortality data for St. Agnes Hospital, Fond du Lac, Wisconsin, and Waupun Memorial Hospital, Waupun, Wisconsin; we would like to make the following comments:

Both hospitals and their medical staffs are committed to providing the highest quality of care possible. We find the mortality statistics a valuable addition to our quality assurance program, but feel that the data should not be interpreted by the public as the sole criteria for determining the quality of care at our hospitals or any other hospital. The data do not take into account the difference in severity of illness that hospitals experience based on the level of service provided. Hospitals that are involved in providing care for terminally or critically ill patients, or who receive large numbers of transfers will experience higher mortality rates. Local availability of nursing home beds, hospice programs and home health care also have an effect on where people die. Applying the same statistical formula to all hospitals without accounting for severity of illness may produce information that the public could easily misinterpret.

Approximately 25 percent of the patients identified in St. Agnes Hospital's mortality data died within the 30 day period after discharge. We have no way of verifying that these deaths were attributable to the reason for the patient's hospitalization. The fact that a patient died within 30 days after a hospital discharge does not directly reflect on the quality of care provided by a facility or the patient's attending physician.

We appreciate the steps that HCFA has taken to improve the statistical model used in generating the mortality data, but there is still much that should be taken into account. The care of Medicare patients is complex and involves more than just hospital and physician services. Outcomes are dependent on a range of factors including preventative care, family support, timeliness of referral to medical specialists, and the patient's personal responsibility for health decisions.

In conclusion, we would like to once again state that hospitals will find the mortality statistics a valuable tool in identifying areas of performance that need to be reviewed in greater depth. We plan to use the data as another of the many monitors we now use to identify areas of focused review.

Thank you for this opportunity to comment.

James J. Sexton
President

Saint Croix Valley Memorial Hospital
& Chemical Dependency Center

204 South Adams Street
Saint Croix Falls / Wisconsin 54024

WI Tel: 715 483•3261 / MN Tel: 612 465•6665

October 22, 1987

Health Care Financing Administration
Health Standards and Quality
Hospital Mortality Bureau
P.O. Box 26684
Baltimore, MD 21207

To Whom it May Concern:

COMMENTS ON THE HCFA MORTALITY DATA

The data used by HCFA indicate that a total of 46 Medicare patients admitted to St. Croix Valley Memorial Hospital died within 30 days of admission during 1986. 32 died while still a patient of the hospital, while 14 died after discharge. Of the 32 deaths, 20 were admitted for terminal care or admitted with "Do Not Resuscitate (DNR)" orders. HCFA data indicate 451 Medicare admissions in 1986. Our own records indicate 778 Medicare admissions in 1986. Presumably the discrepancy reflects multiple admissions of individual beneficiaries. We have no way of verifying whether the number of Medicare patients treated at St. Croix Valley Memorial Hospital is correct. Our own records also indicate that of the 46 Medicare patients who died within 30 days of admission while still an inpatient, 14 were still alive at the time of discharge. (It is impossible to determine the percentage of the 14 patients dying after discharge who were, in fact, alive, as information concerning death after discharge is not included in the patient's medical record.)

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

REMARKS

In none of the diagnostic categories does the hospital's actual mortality rate fall outside of the range of predicted mortality rate.

Using 778 total Medicare discharges for 1986 the mortality rate is 5.9% rather than the 10% reported by HCFA.

Sincerely,

James C. Bigogno
Chief Executive Officer

JCB/mk

ST ELIZABETH HOSPITAL A Member of the Wheaton Franciscan System
1506 SOUTH ONEIDA STREET APPLETON, WISCONSIN 54915

October 23, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltiore, MD 21207

Dear Sirs:

Enclosed please find our comments to your Mortality Data, and a separate packet of corrections to your statistics. Please understand that we intend that only our comments be published with your data.

Thank you.

Sincerely,

ST. ELIZABETH HOSPITAL

Daniel L. Rorabeck
Vice President, Finance

cr
Enclosures

1506 SOUTH ONEIDA STREET • APPLETON, WISCONSIN 54915 • [illegible]

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

COMMENTS ON HCFA DATA

St. Elizabeth Hospital recognizes that consumers have a legitimate interest in obtaining, useful, reliable information on the quality of care available to them. However, mortality rates, by themselves, do not measure quality. Mortality data is most appropriately used to guide or focus peer review.

Quality of patient care is of the utmost concern to the Board of Directors, management and medical staff of St. Elizabeth Hospital. Any indication of potential quality problems, including a mortality rate that is higher or lower than predicted, leads to a prompt investigation to determine if a problem, in fact, exists.

St. Elizabeth is in support of HCFA's stated intention of providing hospitals with an added focus for quality review through the release of mortality data. We also agree with AHA that the publication of data alone, does not indicate hospital performance or quality.

The HCFA data set, as shared with hospital administrative personnel, seems to be based on the number of claims processed in 1986 as an indication of the number of Medicare inpatient admissions. This fact coupled with the utilization of only the last of any admissions of a single beneficiary occurring in 1986 and the exclusion of any stays of more than 30 days, vastly reduces the number of admissions studied. The resultant mortality rate does not reflect a full year's data, and appears greater than the actual mortality rate. Our data, based on actual discharges, appears in contrast to HCFA's as follows:

	HCFA's Data	St. Elizabeth Hospital Data
Total Medicare Inpatients	1,661	2,387
Total Medicare Hospital Deaths	175 (10.53%) (144 while inpatients 31 post discharge)	155 (6.49%) (all 155 while inpatients)

Both the released statistics and our actual numbers place our mortality rate well within the range of predicted rates in all diagnostic categories. This is in spite of the specialty services that St. Elizabeth provides in the areas of trauma, oncology, neuro-surgery, and neuro-rehabilitation.

We have verified each of the deaths as presented in the HCFA data, and are in basic agreement in all cases but one. Minor differences in actual dates of death occur in three cases. We are in the process of conducting additional quality review on each of these cases. However, given the diagnoses, age group, and case mix involved, we expect to validate the delivery of quality health care in each circumstance.

The principal "technical" issue is that the ability of the model to detect differences in quality has not been evaluated. For example, the model does not include measures of severity. Additionally, HCFA data are not all-inclusive. The mortality rates only apply to Medicare patients. The American Hospital Association and other organizations, including the Joint Commission, are investigating methods of evaluating hospital quality that rely on measures other than mortality rates, St. Elizabeth Hospital looks forward to the results of those efforts, we believe that better measures for the public are needed.

ANALYSIS OF REPORTING ERRORS

DIAGNOSTIC CATEGORY	DEATHS REPORTED BY HCFA		DEATHS VERIFIED BY HOSPITAL	
	IN-HOSPITAL	POST-HOSPITAL	IN-HOSPITAL	POST-HOSPITAL
CA--Cancer	33	8	37 (a)	8
CE--Cerebrovascular Accidents	13	1 (3)	17 (b)	0
GC--Gastrointestinal Catastrophes	4	1	4	1
GI--Gastrointestinal Disease	7	2 (4)	8 (c)	1
GU--Urologic Disease	0	1	0	1
GY--Gynecologic Disease	0	0	0	0
HL--Low Risk Heart Disease	2	0	2	0
HM--Severe Chronic Heart Disease	11 (1)	3	11 (d)	3
HS--Severe Acute Heart Disease	20	0	20	0
ME--Metabolic/Electrolyte Disturbances	4	0	4	0
OP--Orthopedic Disorders	1	0	1	0
PN--Pulmonary Disease	14	4	14	4
RN--Renal Disease	1	1	1	1
SE--Sepsis	3	1	3	1
TR--Severe Trauma	3	0	5 (e)	0
EY--Ophthalmologic Disease	0	0	0	0
UN--Other Diagnoses	28 (2)	9	28 (f)	10 (2a)
TOTAL--ALL CATEGORIES	144	31	155	30

WI 117.2

(1) Includes a patient never hospitalized at St. E's
(2) Includes a patient listed as dying while an inpatient at our hospital-our records indicate that she was discharged alive. DOA to E.R. 4 hours post discharge.
(2a) Indication of the previously mentioned patient
(3) Includes a patient that died during hospital stay--not post discharge
(4) Includes a patient that died during hospital stay--not post discharge
(a) Includes 4 patients not indicated by HCFA due to length of stay or multiple admissions status.
(b) Includes 3 patients not indicated by HCFA due to length of stay or multiple admissions status.
(c) Includes 1 patient not indicated by HCFA due to length of stay or multiple admissions status.
(d) Includes 1 patient not indicated by HCFA due to length of stay or multiple admissions status.
(e) Includes 2 patients not indicated by HCFA due to length of stay or multiple admissions status.
(f) Includes 1 patient not indicated by HCFA due to length of stay or multiple admissions status.

(Attachment III)

ST. FRANCIS HOSPITAL
3237 SOUTH 16TH STREET | P.O. BOX 15750 | MILWAUKEE, WI 53215 | 414/647-5000

HCFA MORTALITY DATA COMMENTS

For more information, contact:
Mark V. Knight
Executive Vice President
St. Francis Hospital
(414) 647-5622

Thank you for the opportunity to provide comments on the Health Care Financing Administration's 1986 Mortality Data. St. Francis Hospital's mortality rates were well within the predicted ranges both overall and for each diagnostic category.

We carefully reviewed the mortality cases for St. Francis Hospital and found the data to be accurate. Accordingly, the comments we do have will be brief.

St. Francis Hospital firmly believes that the quality of care provided by hospitals is a justifiable issue for public concern. The quality of care also is of the highest concern of this hospital's Board of Directors, Medical Staff, Administration, and each employee. Consistent with this belief, we have established a comprehensive program designed to ensure the quality of care provided to the Southside Milwaukee community. All quality concerns - no matter how small - are thoroughly investigated and any needed corrective steps are taken. At St. Francis Hospital we do more than measure quality; we work hard to ensure it as well.

The Quality Assurance Program of St. Francis Hospital looks not only at mortality cases, but also infection rates, complications, surgical cases, use of blood components and other aspects of care. The care our patients receive is closely monitored while they are in the hospital so that any concerns are resolved immediately, or even before they occur.

St. Francis Hospital welcomes the release of HCFA Mortality Data, as well as the future development of more sophisticated and appropriate measures of the quality of care.

October 26, 1987
St. Francis Hospital
(ID #520078)

MVK:mp/M2

St. Francis Medical Center

700 West Avenue South
La Crosse, Wisconsin 54601-4783
(608) 785-0940

Philip H. Utz, M.D.
Medical Director
Director of Medical Education

October 21, 1987

Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

HOSPITAL PROVIDER NUMBER: N520004

In reviewing the mortality rates established for St. Francis Medical Center in 16 selected categories we are pleased to see that in all selected categories SFMC falls within the predicted ranges as established by the Health Care Financing Administration.

The 1986 mortality statistics published by HCFA indicates that out of a total of the 2,073 medicare patients admitted to SFMC, 12% died within 30 days of admission. (Our records indicate that we admitted 3,200 medicare patients during 1986; the discrepency presumably reflects multiple admissions of individual beneficiaries to the hospital.) Of these deaths, 19% (49) of the medicare patients in the statistics from HCFA did not die while a patient at SFMC, but died after discharge from SFMC. We cannot determine what the 49 died from since we have no way of determining the cause of death after discharge. Patients who died outside of the hospital may have died from non-related diagnoses. We did find two errors in the data provided, one incorrect date of death reported and in one case no surname was provided and it was impossible to verify. The specific cases are attached.

It is important to note that the method used to calculate the predicted range has yet to be validated and we would question those ranges as broad as for example, 0-100% predicted mortality in the ophthalmological disease category. According to the model developed by HCFA, 95% of all values are expected to fall within the limits of this range. We would like to see further clarification of the ranges developed for predicted mortality.

The average age of patients treated at SFMC in the 16 diagnostic categories is 80.0 years, while the average age overall of medicare patient deaths nationwide is 77.59 years. Today we are seeing a more elderly population with a myriad of diagnoses and accompanying illnesses or complications. Patients are much sicker when they come to a hospital and this, what we call higher acuity, is not considered accurately in statistical models. Health care has changed over the years and we are providing more home care programs, to allow patients with milder illnesses to stay home longer. For these and other reasons only the seriously acute and unstable patients are admitted, which then skews the mortality rates higher.

These issues are not addressed in any statistics, but are important issues for the health care providers today as well as for the patient.

Review of deaths is only one Quality Monitoring tool used in our medical center. We have a well established quality assurance program as reflected by our accreditation from the Joint Commission on Accreditation of Hospitals. Our very recent survey showed that we meet the high standards of quality review important for quality care. Our quality assurance activities include a review system by physicians and other professionals, helping us maintain well-established excellence in health care delivery as reflected by JCAH accreditation, our industry's seal of excellence.

Specific quality review monitoring beyond just review of deaths include:

1. daily quality and content review of patient's written medical records.

2. review of all medical, surgical and diagnostic procedures done at the medical center.

3. ongoing blood usage review using clinically valid criteria to justify all transfusions.

4. each Medical Staff Department (Medicine, Surgery, Family Practice, etc.) reviews the care conducted by each physician monthly.

5. all hospital departments giving patient care (Nursing, Physical Therapy, etc.) are regularly monitored and reviewed.

6. monitoring of appropriate use of all ancillary services, (eg. lab, x-ray, physical therapy, Emergency Medical and Trauma Center using clinically valid indicators, established to measure quality of patient care.

7. specific problem studies to monitor quality of care and efficient utilization of hospital services.

8. medication review studies using national standards of care criteria.

We feel that the public deserves reports on the safety and effectiveness of physician and hospital care. Mortality rates are the minimum beginnings.

Sincerely,

Philip H. Utz, M.D.
Medical Director

PHU/kd

St. Francis Medical Center

700 West Avenue South
La Crosse, Wisconsin 54601-4783
(608) 785-0940

Philip H. Utz, M.D.
Medical Director
Director of Medical Education

Hospital Provider #N520004

Corrections to HCFA data provided:

[redacted]

HCFA reported date of death: 10-29-86
Correct date of death: 10-31-86

[redacted]

No surname provided, unable to verify

St. Joseph's Hospital of Arcadia, Inc.
464 South St Joseph Avenue
Arcadia Wisconsin 54612
(608) 323-3341

Comments on the HCFA Mortality Data

Data Verification

St. Joseph's had 159 Medicare Admissions in the year 1986. Sixty-seven of the 96 HCFA defined cases were categorized into 12 diagnostic categories. Twenty-nine of the 96 were not categorized.

Interpretive Remarks

There was only one category where SJHA exceeded the Range of Predicted Mortality Rates: Renal disease. There were only two cases in this category, yielding a mortality rate of 100%. This number is concluded to be statistically insignificant, due to low numbers. In both cases, SJHA followed family wishes to avoid extraordinary efforts.

It is further generally concluded that, due to low volumes, the value of any statistical review or comparison to predicted ranges in other categories is questionable.

However, all mortalities occurring at SJHA are reviewed by the Medical Director and the Medical Staff Committee of the Whole. It is believed this review process is an effective means to identify quality-of-care issues in a thorough manner.



St. Joseph's Hospital

2661 County Trunk I, Chippewa Falls, WI 54729 • (715) 723-1811

COMMENTS TO ACCOMPANY DECEMBER RELEASE FROM HCFA REGARDING MORTALITY RATES

While we do concur with the mortality rates given by HCFA for St. Joseph's Hospital, it is important to note that such rates, by themselves, do not measure quality. Quality can only be evaluated through the process of peer review.

The mortality rates at St. Joseph's Hospital fall very low within HCFA's predicted ranges and reflects the strengths of our hospital's quality assurance programs to ensure the highest standards of care for our patients. Quality of care is of the utmost concern to the administration, staff and physicians of St. Joseph's Hospital.

Furthermore, figures used by HCFA are for the "average" hospital patient. Actual mortality rates can be higher or lower than the predicted rates because the patients treated, or the care provided by a hospital, differs from the patients or care in the "average" hospital. There are many variables involved when discussing the patients, for example, how ill the patient was at the time of admission, was the patient transferred from a nursing home, was the patient receiving treatment at home prior to admission, did the patient have a terminal illness, and if the patient died after discharge, can the death be attributed to the reason for admission to the hospital.

Data supplied by HCFA is not all-inclusive. In addition, the mortality rates apply only to Medicare patients - the older, often "higher risk" patient population. The American Hospital Association and Joint Commission on Accreditation of Healthcare Organizations are investigating methods of evaluating hospital quality based on measures other than mortality rates - better measures for the public are needed.

# # # # #

Bill Larson
Community Relations Coordinator

bll

"so much care . . . so close"



St. Joseph's Community Hospital
of West Bend, Inc.

551 SILVERBROOK DRIVE, WEST BEND, WISCONSIN 53095
PHONE (414) 334-5533



Medicare Provider Number: 520063

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Executive Director
Mr. Fred J. Bury

October 12, 1987

William L. Roper, M.D.
Administrator, Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

I would like this letter printed as a response to your release of information regarding Medicare mortality statistics.

Our hospital received your letter dated September 21, 1987, in regard to the release of mortality statistics for Medicare patients. I disagree completely with your conclusions that this data will be of value to the general public and to employers or even to the hospitals to whom it is supplied. I will admit the possibility exists that it may be of some epidemiologic value and of value to researchers looking at large population groups. The data is simply too incomplete to be of value. For an individual hospital, especially the smaller ones, the data will have little meaning.

As you are aware, journalists, and the readers of newspapers and periodicals, will look for the most obvious quick insight that they can get into the data. The death rate for all causes will catch their eye immediately and that percentage will be extrapolated by them and that number will be given much more meaning than it deserves. As an example, the overall mortality for our hospital for 1986 for Medicare patients is 10 percent. However, this does not mean that every patient admitted to our hospital has a one in ten chance of dying. It does not even mean that every Medicare patient has a one in ten chance of dying. The number of Medicare patients, not the number of Medicare admissions, was used as the denominator in arriving at the ten percent figure. I doubt that anybody will take the time to read the report carefully enough to make that distinction when they form their headlines for the newspaper. I know that this distinction will not be made in the minds of the readers, even if the journalists attempt to make this distinction.

In addition, I feel that the data you are making available does not reflect the severity of the illnesses treated by a particular hospital. Some hospitals treat patients who are more severely ill than other hospitals. In addition, you have lumped the deaths into sixteen very broad categories. It tends to lump various conditions together that are not necessarily related. The categories are not specific enough. Another criticism of the report is that the deaths are being reported under the principal admitting diagnosis, which may not necessarily be the illness or disease causing death. We all know the limitations of the admitting diagnosis as defined by Medicare, but the general public and the press do not. Another criticism is the fact that deaths within 30 days of hospitalization are counted as a hospital death. Factors totally beyond the control of the hospital or the discharging physician may have been responsible for the patient's death, but this does not appear as a factor in the statistics made available by you.

I think the publication of these figures is meant to be sensationalistic and serves no useful purpose. I disagree with the accumulation of and with the wide public dissemination of these figures when they have little or no value.

Sincerely,

William J. Listwan

William J. Listwan, M.D.
President, Medical Staff

WJL:jfl

SAINT JOSEPH'S HOSPITAL (520037)

A MEMBER OF MINISTRY CORPORATION
SISTERS OF THE SORROWFUL MOTHER

COMMENTS ON HCFA MORTALITY DATA

The HCFA mortality data indicates that St. Joseph's Hospital's mortality rates fall within the HCFA predicted ranges for Medicare patients treated during 1986. The reader should keep in mind several factors when reviewing this data:

1)Although the predicted mortality rate was based on several factors that were theorized to impact mortality rates, the factors have not been verified as valid indicators of mortality.

2) This data should only be used as screening data, and not as an indicator of quality. It may be used to point to areas that warrant further review and explanation, however the data in and of itself does not indicate either good or bad quality of care provided.

3) St. Joseph's Hospital provides a variety of special services which would have an impact on the mortality rate because of the nature of the illness or disease process of patients utilizing those services. These services include:

-A Hospice Program
-An Open Heart Surgery Program
-A Referral Center Cancer Treatment Program
-A Renal Dialysis Program

4) St. Joseph's Hospital serves as a major referral center for northern and central Wisconsin. As a result, patients who are more critically ill and in need of complex treatment are often transferred to St. Joseph's Hospital for their care. Our case mix index, which is the HCFA method of measuring severity of illness, ranks as the 3rd highest in the state of Wisconsin.

5) St. Joseph's Hospital also has a comprehensive Quality Assurance Program which includes total review of all patients using a set of quality indicators. As a part of this review, all deaths that occur in the hospital are reviewed on an on-going basis.

David R. Jaye
David R. Jaye
Chief Executive Officer

Oct 23 1987
Date

0004s

611 SAINT JOSEPH AVENUE
MARSHFIELD, WISCONSIN 54449

St Joseph's
HOSPITAL · MILWAUKEE

5000 West Chambers Street · Milwaukee, WI 53210 · 414 447-2000

October 23, 1987

William L. Roper, M.D, Administrator
Health Care Financing Administration
Department of Health & Human Services
6325 Security Blvd.
Baltimore, Maryland 21207

Dear Dr. Roper:

We welcome the opportunity to respond to the Medicare mortality rate information we have received from the Health Care Financing Administration.

Though the data supplied indicates that St. Joseph's Hospital Milwaukee falls within the range of predicted mortality rates for all 16 categories, we wish to express several concerns. They include:

- Though we are near the top of the range in the Cancer category, it should be noted that 20 per cent of our deaths occurred within our Hospice. Therefore, the higher rate would be expected.

- Because four categories -- Opthalmologic Disease, Gynecologic Disease, Renal Disease, and Sepsis -- include fewer than 50 cases and therefore a small volume, the statistical reliability may be questionable.

- The deaths identified as taking place outside of the hospital are, in some instances, inaccurate due to readmission after discharge.

- We do not know to what other institutions -- or their acuity of care and service specialties -- we are being compared. Therefore, maximum analysis is difficult at best.

- At this time, we do not understand the precise methodology of measurement established by HCFA. Therefore, it makes our analysis of the information difficult.



In conclusion, we do not feel the mortality data provides a definitive measurement of quality of care, nor does it directly translate into appropriate or inappropriate hospital care or behavior.

These mortality rates are a gross measurement of hospital care. St. Joseph's Hospital, fully accredited by the Joint Commission on the Accreditation of Healthcare Organizations, possesses an active and comprehensive Quality Assurance process.

This process includes physicians, representatives from all departments directly involved in direct patient care, administrators and members of the Board of Directors. Monitoring all patient care throughout the hospital, the Quality Assurance process at St. Joseph's takes into account the severity of illnesses as well as diagnosis and complicating factors.

Again, thank you for the opportunity to reply to this data.

Sincerely,

Thomas L. Feyrig
President

St. Joseph's
MEMORIAL HOSPITAL AND HOME
400 WATER AVE ○ HILLSBORO, WI 54634
(608) 489-2211

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P. O. Box 26684
Baltimore, Maryland 21207

Dear Dr. Roper:

COMMENTS ON THE HCFA MORTALITY DATA

Data Verification

The data used by HCFA indicate that a total of 37 Medicare patients admitted to St. Joseph's Memorial Hospital in 1986 died within 30 days of admission. Of these, 25 died while still a patient of the hospital, while 12 died after discharge.

Our own records indicate that 400 Medicare admissions occurred in 1986, compared to 252 as reported by HCFA. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at St. Joseph's Memorial Hospital is correct.

Our own records verify the 25 deaths which occurred as hospital inpatients. However, of the 12 deaths occurring post-discharge which HCFA attributes to St. Joseph's Memorial Hospital, 1 patient was transferred to another acute care facility and presumably died there, reducing the number of post-discharge deaths attributable to our facility to 11. Of these 11 patients dying after discharge, we are able to confirm only 6 deaths. It is impossible to determine the percentage of the remaining 5 patients dying after discharge who were, in fact, alive, as information concerning their deaths is not included in their medical records.

Our records then would indicate a total of 36 deaths attributable to St. Joseph's Memorial Hospital, rather than the 37 as reported by HCFA, which in turn reduces the actual mortality rate for all cases as determined by HCFA from the reported 15% to 14%. Based on our figures of 400 Medicare admissions, the overall mortality rate for Medicare patients would be 9%.

Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

STJ

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

St. Joseph's
MEMORIAL HOSPITAL AND HOME
400 WATER AVE ○ HILLSBORO, WI 54634
(608) 489-2211

Attached is a corrected case listing which includes corrections on two patients (one of which was transferred to another acute care facility and is therefore not a death attributable to St. Joseph's Memorial Hospital and one which has incorrect admission and discharge dates.)

Interpretive Remarks

Of the 11 post-hospitalization deaths, 9 occurred in SNF's. Patient condition at the time of transfer in 4 of these 9 cases was considered terminal. Of the remaining 7 cases, 4 patients had multiple serious medical problems/complications occurring during their hospitalizations and/or serious chronic conditions for which they were undergoing continuing treatment, for which death was a significant possibility.

In none of the diagnostic categories did the hospital's actual mortality rate fall outside the range of the predicted mortality rate.

Unique Services Resulting in Higher than Average Mortality

Again, the hospital's actual mortality rate did not fall outside the predicted mortality rate in any of the diagnostic categories. However, the actual mortality rate for the diagnostic category of cancer was on the high end of the range of predicted mortality rates (50% actual rate, 11% - 52% predicted range). The provision of hospice services for cancer patients by the hospital may understandably result in a higher mortality rate for this category.

Of the 9 deaths occurring within this diagnostic category, all of the patients had long-term diagnoses of cancer and most had been receiving hospice services through the hospital. Death was expected in all cases.

Sincerely,

Robin H. Johnson
CEO/Administrator

RHJ:dw

Encs.

STJ

HOSPITAL = 520016 ST JOSEPHS MEMORIAL HOSP HILLSBORO WI

DIAGNOSTIC CATEGORY	CASES	ACTUAL MORTALITY RATE	RANGE OF PREDICTED MORTALITY RATES
ALL CAUSES	252	15 % *	8 TO 18 %
CA - CANCER	18	50 %	11 TO 52 %
CE - CEREBROVASCULAR ACCIDENTS	14	21 %	12 TO 57 %
GC - GASTROINTESTINAL CATASTROPHES	8	0 %	2 TO 55 %
GI - GASTROINTESTINAL DISEASE	32	0 %	1 TO 21 %
GU - UROLOGIC DISEASE	12	17 %	0 TO 49 %
GY - GYNECOLOGIC DISEASE	1	0 %	0 TO 100 %
HL - LOW-RISK HEART DISEASE	19	11 %	1 TO 30 %
HM - SEVERE CHRONIC HEART DISEASE	22	32 %	10 TO 45 %
HS - SEVERE ACUTE HEART DISEASE	5	40 %	7 TO 76 %
ME - METABOLIC/ELECTROLYTE DISTURBANCES	5	20 %	1 TO 69 %
OP - ORTHOPEDIC DISORDERS	15	0 %	0 TO 68 %
PN - PULMONARY DISEASE	26	19 %	10 TO 42 %
SE - SEPSIS	2	0 %	1 TO 89 %
TR - SEVERE TRAUMA	11	9 % **	1 TO 44 %

* Corrected figure is 14%

** Corrected figure is 0%

St. Luke's Hospital

October 26, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Sir:

Overall, in review of the 1986 Medicare mortality rate data that was forwarded to St. Luke's Memorial Hospital, Inc. several errors have been detected, some of which impact statistical accuracy. Specifically:

* Six out of one hundred ninety-four reported deaths (3.09%) had the incorrect expiration date listed.

* Six out of thirty-two individuals (18.75%) that were listed as expiring within 30 days after discharge were patients of the hospital at the time of death (one individual was actually a patient at St. Mary's Medical Center).

* One patient reported as dying at St. Luke's Hospital was only treated at our facility, and expired at St. Mary's Medical Center. This death was incorrectly attributed to St. Luke's Hospital's statistics.

* One patient who was admitted and expired in 1987 was listed as a 1986 statistic.

The death certificates and records of thirty-two individuals who were listed as 30-day post discharge mortalities from St. Luke's Hospital were examined closely. As stated above, six of the thirty-two individuals should have not been included in this figure, leaving a total of twenty-six deaths within thirty days of discharge. In eight of the twenty-six deaths (30.7%) there was an uncertain relationship between the cause and reason for death and the diagnosis and reason for admission.

1320 Wisconsin Ave.
Racine, WI 53403
414-636-2011

After the review of these thirty-two individuals, all remaining charts were verified to assure accuracy of admission, discharge and death rates. In addition, approximately 50% of those remaining charts were randomly selected and reviewed in detail to denote trends in specific patient characteristics such as diagnosis, treatment and subsequent causes of death. The following information was obtained:

* A "Do Not Resuscitate" (DNR) instruction was listed on 93% of the charts and in 90% of the cases a chronic health condition existed where death was both an imminent and expected outcome.

* Approximately 39% had a primary diagnosis of cancer and either already were or subsequently became hospice patients. In 1986, St. Luke's Hospital had the majority of cancer discharges in the city of Racine and is the only provider of radiation therapy and hospice services in the area. St. Luke's also provides end-stage renal dialysis, which is a service that attracts patients with a higher than average expected mortality.

* Approximately 19% of the patients were identified as having been transferred from a nursing home facility with chronic degenerative conditions shortly before death. Racine County currently has an acute shortage of nursing home beds.

Based on the above facts, it is clear that the HCFA data, in itself, is not a clear measurement of hospital performance and should not be utilized as the sole basis for judging quality of care.

Respectfully submitted,

Ray Di Iulio
President

RLD/dc

ST. MARY'S HOSPITAL
O·Z·A·U·K·E·E

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

RE: Medicare Mortality Data

Dear Dr. Roper:

Attached please find commentary about the Medicare Mortality Data for St. Mary's Hospital Ozaukee, Inc., Port Washington, Wisconsin (Provider #520027). The commentary outlines concerns about the methodology used to make judgements about the quality of care provided and data related specifically to the experience of St. Mary's Hospital Ozaukee, Inc.

Sincerely,

Charles C. Lobeck/BR

Charles C. Lobeck
Senior Vice President

CCL/br

Attachment

HCFA MORTALITY DATA ANALYSIS

By St. Mary's Hospital Ozaukee, Inc.
Port Washington, Wisconsin

The following commentary is a result of a detailed analysis of the HCFA Mortality Data for St. Mary's Hospital Ozaukee, Inc., Port Washington, Wisconsin (Provider #520027), for admissions between December 31, 1985 and December 31, 1986.

St. Mary's Hospital Ozaukee is a 94 bed community hospital providing primary care services. It is the only hospital in Ozaukee County, Wisconsin. We would like to state that the use of mortality rates as indicators of health care service or quality is inappropriate and spurious. In the sixteen diagnostic categories identified, mortality rates at St. Mary's Hospital Ozaukee fell within predicted ranges in all but one, Severe Acute Heart Disease.

Severe Acute Heart Disease

The mortality rate of 75% in this diagnostic category fell outside the predicted range of 19 - 71%. This rate is based on a statistically insignificant sample of twelve cases involving nine patient deaths. The nine patient mortalities had an average age of 80.4 years, with four patients aged over 85 years. Four of these nine cases were under "Do Not Resuscitate" orders based on family and physician decisions. Three other patients experienced severe complications including diabetes, COPD, and chronic heart conditions that contributed to death. All records involving patient deaths are reviewed by a panel of physician providers for appropriateness and quality of services provided.

ST. MARY'S HOSPITAL
M·I·L·W·A·U·K·E·E

Sister Julie Hanser, D.C.
PRESIDENT

October 23, 1987

Mr. William L. Roper
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, DC 20201

RE: Medicare Mortality Data

Dear Dr. Roper:

Attached please find commentary about the Medicare Mortality Data for St. Mary's Hospital of Milwaukee, Wisconsin, Provider #000000108. The commentary includes discussion regarding concerns about the methodology used to make judgments about the quality of care provided and data related specifically to St. Mary's Hospital of Milwaukee's experience.

Sincerely,

Sister Julie Hanser
President and Chief Executive Officer

SrJH/kwm
Enclosures
cc Sister Irene Kraus, President, Daughters of Charity National Health System
William Proxmire, US Senator, Wisconsin
Robert W. Kasten, Jr., US Senator, Wisconsin
James P. Moody, US Representative, 5th District

2323 North Lake Drive • P.O. Box 503 • Milwaukee, WI 53201-0503 • Phone 414-225-8008
Member Daughters of Charity Health System—East Central

HCFA MORTALITY DATA ANALYSIS
by
St. Mary's Hospital of Milwaukee
Milwaukee, Wisconsin

The following commentary is the result of a detailed analysis of the HCFA Mortality Data for St. Mary's Hospital of Milwaukee, Wisconsin, Provider #000000108 for admissions between December 31, 1985 and December 31, 1986.

St. Mary's Hospital of Wisconsin is a 314 bed tertiary care facility. It is the oldest private hospital in the State of Wisconsin. It is a member of the Daughters of Charity National Health System, East Central Region. St. Mary's specializes in a variety of services including cardiology, cardiovascular surgery, high risk obstetrics and gynecology, oncology, hospice care, cardiac and physical rehabilitation, orthopedics, Parkinsonism and multiple sclerosis.

First of all, we continue to oppose the HCFA approach of providing information about so called "quality care" in hospitals. The use of mortality statistics is inadequate for accurately measuring the quality of care in hospitals. The results for our hospital in this year's edition appear to be generally positive. However, we do not intend to "crow" about our position because we do not believe that the method is legitimate. We are truly committed to quality care and to the assessment and assurance of quality care. As will be shown in this commentary, we have taken a leadership position both in our local community as well as in the largest non-profit system of health care in America, namely the Daughters of Charity National Health System, by piloting the use of severity adjusted measures of quality and efficiency.

The problems with these statistics are the following:

- HCFA has determined the expected death rate at St. Mary's of Milwaukee to be between 9-15%. As reported by HCFA our actual rate is 13%. A closer examination of the data indicates that of the 270 deaths reported, 79 were deaths in our hospice program. These deaths have been review by WIPRO, the state-wide professional review organization, working under guidelines from HCFA. According to WIPRO all these admissions were justified utilizing the criteria that HCFA has imposed upon WIPRO.

- HCFA reports that 28 deaths occurred after discharge. We found that five of these patients were actually inpatients at the time of death. An additional 13 patients were being cared for at home. Two patients were actually in our inpatient hospice program at the time of their death and seven others died in skilled nursing facilities. This information illustrates the danger of interpretating death rates without significant amounts of additional information. The HCFA methodology did not address the hospice issue for the second time.

- HCFA has acknowledged its inability to adjust for severity when releasing these data. St. Mary's Hospital of Milwaukee, however, has utilized for almost two years the MedisGroups approach to severity adjusted quality and resource utilization. The MedisGroups system

collects various information about patient care including outcome and resource use. The system allows us to categorize patients on admission to severity categories 0-4. A category of 0 indicates a low degree of severity on admission whereas a score 4 indicates the highest degree of severity. The differences between the categories are statistically significant.

- Using the MedisGroups system we have analyzed the 270 deaths reported by HCFA. Briefly, we would like to comment on these data:

  - The average admissions score for all patients was 2.5. Such patients represented a very sick population with truly acute symptoms and a high potential for organ failure.

  - The non-hospice patients had an average admission severity score of 2.7 which indicates that they were even sicker than the average. For example, hospice patients as a group averaged 1.8 in severity on admission. We note that these patients had a lower average severity score but were terminally ill on admission.

  - In the cancer category St. Mary's death rate exceeded the expected range, 43% vs. a HCFA expected range of 22-37%. Of the 216 cases in this category, 61 patients were hospice patients. The severity score for the non-hospice patients was 2.4.

  - HCFA reported that in the only other category in which St. Mary's exceeded the range, low risk heart disease, St. Mary's was reported to have an 8% rate vs. a range of 3-7%. The severity score for this group was 2.3. Of the 41 patients in this group, 17 patients had coronary artery bypass grafts in three or more arteries. Eleven of these same patients had diabetes as well as heart disease. Twelve of the 17 patients had four or more arteries which underwent bypass surgery. This indicates to us that the category for low risk heart disease, as generated by HCFA, was seriously flawed. Several surgeons at St. Mary's Hospital are noted for treating the most severely ill heart patients in the United States. This group of patients, as reported by HCFA, included individuals who had been turned down for surgery at other heart centers in the United States.

St. Mary's Hospital of Milwaukee has a strong quality assessment program. We have taken the lead in developing and utilizing severity adjusted quality data. We support efforts to provide consumers and payors of health care services the data necessary to inform their decisions. In fact, we have worked closely with the business coalitions in the Southeastern Wisconsin area in order to develop collaborative approaches to data gathering and the sharing of data.

However, we strongly disagree with the approach that has been taken by HCFA. We will continue to work toward developing more useful, accurate and appropriate tools. We invite HCFA to work more closely with us as providers of health care in developing appropriate measurements and instruments for informing those individuals who receive our services or purchase our services.

SACRED HEART-SAINT MARY'S
HOSPITALS, INCORPORATED

A MEMBER OF MINISTRY CORPORATION
SISTERS OF THE SORROWFUL MOTHER

October 9, 1987

Data Verification:

The data indicate that 122 Medicare patients admitted to St. Mary's Hospital died within 30 days of admission. Ninety-seven died while still a patient and 25 died after discharge.

All deaths reported by HCFA as occurring during hospitalization were verified with the exceptions listed on the attached page. In addition, four Medicare inpatient deaths per hospital records were not recorded on the HCFA listing.

Interpretive Comments:

Review of deaths in the cancer category by the Quality Assurance Committee showed that in about 85% of cases, death was the expected outcome to the advanced stage of the cancer. In the remaining 15%, death was a significant possibility at the time of admission.

Review of the one death in orthopedic disorders and the two deaths in the severe trauma category showed that the principle diagnosis was not related to the actual cause of death. These patients had significant comorbid conditions which caused death.

Carol A. Ritter

Carol A. Ritter, M.D./mc
Chairperson
Quality Assurance Committee

SACRED HEART HOSPITAL
216 NORTH 7TH STREET
TOMAHAWK, WISCONSIN 54487-1496
715-453-2181

SAINT MARY'S HOSPITAL
1044 KABEL AVENUE
RHINELANDER, WISCONSIN 54501-3998
715-369-3311

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

707 South Mills Street
Madison, WI 53715-0450
608 251 6100

St. Marys
Hospital Medical Center
Madison, WI

October 27, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26676
Baltimore, MD 21201

Dear Dr. Roper:

RE: Institution Identifier 520083

Attached is the statement that St. Marys Hospital Medical Center wishes to have published with the mortality statistics for our institution.

Please note our request for correction.

We appreciate the opportunity to be able to place our concerns in the record.

Sincerely,

Gerald Lefert

Gerald Lefert
Executive Director

Attachment

October 27, 1987

William Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
P.O. Box 26676
Baltimore, MD 21201

Institution Identifier #520083

Response to HCFA Mortality Data

I. Correction of Errors

In the review of the 1986 Mortality Data distributed to our institution, we have identified one (1) patient for whom we have no records. [redacted] F, 12/14/86)

Please remove this patient from your tally and correct our institutional mortality rate for the HL, Low Risk Heart Disease category. In addition, we cannot verify the outcome of eighty-two (82) patients, who received care in our institution and were discharged to home, to nursing homes or to hospice programs.

II. Supplemental Information

It is important to identify the special care that our hospital provides and how our position as a referral center impacts on the information presented by HCFA.

Our institution provides Open Heart Surgery as a treatment option for hundreds of cardiac patients every year. The fine reputation that our program and our staff have established attracts patients who are no longer satisfied with medical therapy. One example of this is reflected in the category Low Risk Heart Disease (HL) which includes acute and chronic ischemic heart disease as well as rheumatic heart disease and other valve disorders.

Low Risk Heart Disease

Specific review of the patients we have served in this category reveals five (5) patients with disabling angina despite medical therapy and three (3) patients with severe and symptomatic obstruction of the outflow valve of the heart. Because of the crippling effects of these diseases on each of these patients, surgery was performed at the patient's request despite the known risks. The average age of these patients was 74.5 years.

We do not feel these are patients with Low Risk Heart Disease. Our institution and medical staff request that patients with these illnesses be considered in the category of Severe Chronic Heart Disease or that the entire category be retitled to Disabling Heart Disease--for which heroic measures may be appropriate.

III. Conclusions on Data Collection Methodology

We recognize the importance of maintaining a large and accurate information base to be incorporated in our ongoing Quality Assurance program. HCFA information has been and continues to be forwarded to appropriate review committees in our institution.

We appreciate the right that the consumer has information that will aid in their choices concerning health care. Yet, because the HCFA data is compiled without the use of measures of severity of illness, we caution the use of this data as an indicator of the quality of care provided in this or any other institution. A severity of illness adjustment is an important next step that we sincerely hope the Health Care Financing Administration will incorporate into future publications.

St MICHAEL HOSPITAL
2400 west villard avenue milwaukee, wisconsin 53209 tel (414) 527-8000

October 19, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Health Standards & Quality Bureau
P.O. Box 26684
Baltimore, MD 21207

Dear Doctor Roper:

Mortality rates determined by the statistics on 16 diagnoses for Medicare patients recently received from HCFA, indicate that St. Michael Hospital is within the predicted range for each category. The hospital and its medical staff continue to work very hard to maintain quality care at this institution. Despite this favorable comparison, however, St. Michael Hospital is seriously concerned about the release of information in this format.

In verifying the mortality data, we found that one patient is living even though HCFA data indicates the patient has died. Two patients listed as having died at home actually died in the hospital. Given that there were 318 patient deaths in a patient population of nearly 2600, the overall validity of the data does not appear to be in question.

While the data are fairly accurate, they do not constitute an appropriate measure of quality. The data are of interest to the hospital only because it is published under the aegis of the Federal government and because of the tremendous amount of publicity surrounding its release.

The basic problem is that the data does not account for the acuity of illness and other pertinent clinical circumstances such as the point in time in which the patient presents himself or herself for hospital treatment. As the data are aggregated in order to become statistically relevant, the degree of clinical relevance is sacrificed. It would prove to be nearly impossible to respond to the data in any meaningful way given the size of the data base, limitations of time and resources.

If the purpose of this effort is to inform the public, then the public will probably be misled. A high mortality rate may be indicative of a hospital program which, because of its high quality, attracts the most severe cases.

If the purpose of this effort is to assist providers in addressing quality issues, then please understand that the information is not particularly useful. St. Michael Hospital already has an effective means of conducting mortality reviews. The data are too amorphous for use in our quality assurance efforts.

If the purpose of this effort is to review outcome patterns with respect to Medicare patients, then we are confused. HCFA already sponsors the Professional Review Organization effort (PRO's) whose role it is to monitor the quality of care. This effort has been ongoing since the mid-1970's. We would presume that any mortality problems would have been addressed by now.

St. Michael Hospital recognizes that the public has a legitimate interest in obtaining useful, reliable information on the quality of care available to them. The basic criticism of the HCFA data is that mortality rates do not, by themselves, measure quality.

Sincerely,

John A. Comiskey
President

RH/ks

ST. NICHOLAS HOSPITAL

1601 NORTH TAYLOR DR. • SHEBOYGAN, WISCONSIN 53081-2496 • (414) 459-8300

October 26, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
Room 2D2 - Meadows East Building
Baltimore, Maryland 21207

Dear Dr. Roper:

Thank you for this opportunity to respond to the release of data on hospital mortality rates for Medicare patients treated in our facility during calendar year 1986. Since receiving the report dated September 21, 1987, St. Nicholas Hospital staff has had an opportunity to review the data. The following information for St. Nicholas Hospital is to be attached to the Hospital Specific Report prior to public disclosure.

St. Nicholas Hospital is a JCAH accredited, 185 bed, acute care facility, whose case mix includes many patients with major medical and surgical illnesses. We are a full-service medical center offering care in specialty areas of oncology, radiation therapy, major vascular surgery, major orthopedic services, rehabilitative medicine, including a comprehensive cardiac rehabilitation program, renal dialysis, as well as general medicine and surgery.

The medical staff at St. Nicholas Hospital conducts an intensive review of the medical record of every patient who expires at this facility regarding medical management and overall care. Mortality review is an ongoing process of the quality assurance program, and peer review activities are an integral part of the monitoring of the health care delivery system at this hospital.

The hospital specific mortality data reported by HCFA have been carefully reviewed by our hospital administrators, president of the medical staff, physician chairmen and physician members of the Utilization Review Committee, utilization review coordinator, and the director of medical records.

The data used by HCFA indicate that a total of 1,468 Medicare patients were admitted to St. Nicholas Hospital in 1986. Our own records indicate that 2,133 Medicare admissions occurred, accounting for 38% of our total admissions in 1986. Presumably the discrepancy reflects multiple admissions of individual patients to our hospital. The data further indicate that 224 Medicare patients died within 30 days of admission to our facility. Of these, 178 died while still a patient of the hospital, while 46 died after discharge. The director of medical records has validated that, with minor exceptions, data provided are accurate. In two of the diagnostic categories, the hospital's actual mortality rate falls outside of the range of the predicted mortality rate. After comprehensive review of the medical records by members of our Utilization Review Committee, their findings are summarized as follows:

High Risk Category: HM Severe Chronic Heart Disease

In 1986, 164 patients were discharged from St. Nicholas Hospital with a diagnosis representative of this category. HCFA has identified 84 Medicare patients admitted to our facility in this category, 32 of which died, 24 while hospitalized, and 8 expired within 30 days of discharge from our facility.

Of these 32 patients:

1. 22 patients were over the age of 80

2. 19 patients had multiple admissions within the prior year

3. 10 patients were admitted from skilled care facilities

4. 11 patients died within 24 hours of admission

5. 28 of the patients and/or families in this category, because of their multiple medical problems, requested "no heroic measures" (Do Not Resuscitate Order) to be taken

6. Of the 8 patients that expired within 30 days of discharge, 6 were transferred to skilled extended care facilities

All 32 patients had significant complicating and/or pre-existing conditions on admission, 17 of which had complicating conditions not included in the criteria used by HCFA when developing this study.

High Risk Diagnostic Category: RN Renal Disease

St. Nicholas Hospital is the sole provider within a sixty mile radius of a renal dialysis unit. This unit provides for patients with end stage renal disease and those with temporary kidney failure. The unit also offers training and support for continuous ambulatory peritoneal dialysis (CAPD). The hospital's dialysis program is associated with the treatment program at Froedtert Memorial Lutheran Hospital in Milwaukee. As part of Network 13, we participate in a master patient file data collection and analysis as part of ongoing quality assurance activities as well as intensive peer review. In 1986, 33 patients received the benefit of services provided by our dialysis unit.

In 1986, 28 patients were discharged from St. Nicholas Hospital with a diagnosis representative of the renal category. HCFA has identified 8 Medicare patients admitted to our facility in this category, 5 of which died while hospitalized, and 1 who expired within 30 days of discharge from our facility.

Of these 6 patients:

1. All 6 of the patients and/or families in this category, because of their multiple medical problems, requested "no heroic measures" (Do Not Resuscitate Order) to be taken

2. 2 patients received dialysis, while 2 refused this form of treatment

3. 3 of the patients were over the age of 70, and the remaining 3 were over 85 years of age

4. The patient who expired after discharge was transferred to an extended care facility for hospice-type care

5. 1 patient died within 24 hours of admission

All 6 patients were admitted with a significant number of complicating and/or pre-existing conditions, 4 of whom had conditions not included in the criteria used by HCFA when developing this study.

After indepth peer review of the information obtained from the individual case analysis of these categories, we have concluded that:

1. The patients, for the most part, were placed appropriately by HCFA into the right diagnostic category

2. Because of the severity of illness of these patients, identified by documented complicating and/or pre-existing medical conditions, including the high percentage of patients with conditions not included in the criteria used by HCFA, in this study (53% in the heart category and 67% in the renal category), a higher than the average mortality rate could be expected.

3. The right of each patient and his family to be informed about his illness and to participate in his care decisions was recognized, and the quality of care received was appropriate in all cases.

St. Nicholas Hospital recognizes that consumers have a legitimate interest in obtaining useful, reliable information on the quality of care that is available to them. We also recognize and strongly believe that mortality rates, by themselves, do not measure quality; however, we will continue to further analyze this data, because we recognize its usefulness as a guide or tool to focus peer review.

Quality of care is of the utmost concern to St. Nicholas Hospital's governing board, administration, medical staff, and employees. As has always been our practice, we will continue to review all mortality cases for quality and appropriateness of care rendered to the individual patient. We view continued analysis of trends as a constant endeavor to assist in identifying opportunities to improve care.

Thank you for the opportunity to present this response.

Sincerely,

Michael E. Zilm
Executive Vice President

Sincerely,

James B. Kuplic, M.D.
Medical Staff President

MEZ:caw

cc: L. Malewiski
K. Lensen
S. Schulz
C. Morgenweck

St.
Vincent
Hospital

P.O. Box 13508 Green Bay, Wisconsin 54307-3508 (414) • 433 • 0111

October 27, 1987

Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Hospital Provider # 52-0075

To Whom It May Concern:

Although St. Vincent Hospital's mortality figures fall within or below predicted limits in all of the categories measured here, we, nevertheless question the validity of the information and use of it to imply a measure of quality of care. Here are our major concerns:

- The data does not reflect the severity of patients treated by a hospital.

  As a regional referral center, which gets the most seriously ill and injured patients from Northeastern Wisconsin and Upper Michigan, St. Vincent Hospital is inappropriately compared to smaller hospitals that transfer difficult cases elsewhere.

  By virtue of many of our specialty services such as cancer treatment, renal dialysis, and emergency and trauma care, St. Vincent Hospital would expect to have a higher mortality rate than hospitals which don't offer similar specialty services. We believe it is misleading to the public to compare dissimilar hospitals.

- The data does not reflect the true cause of death in some cases.

  The figures here are based upon deaths occurring within 30 days of a patient's admission to a hospital and categorized according to the primary reason for that particular hospitalization. The data does not indicate whether the death was actually related to the hospitalization.

  For example: A patient is hospitalized for an orthopedic procedure. All goes well. He is discharged. On his way home he is struck by a car and killed. In the data presented here, his death would be listed under orthopedics. This is because his death occurred within 30 days of this hospitalization for the orthopedic procedure.

- <u>The data should not be used to measure quality of care since it excludes significant factors contributing to the cause of death.</u>

  The HCFA data includes all deaths within 30 days of admission whether the deaths were expected or not. In other words, the figures do not take into account preexisting terminal conditions or the stage of a patient's illness when hospitalized. If a patient is admitted to a hospital while in the final stages of terminal cancer or renal disease, the best care technically and humanly possible could both change the outcome. Yet statistics give no indication of such significant contributing factors to the cause of death.

  The patient's medical history, psychological condition and age are also excluded from the data here. These factors, too, may have an impact on the cause of death. The average age, for example, of the St. Vincent patients at the time of death was 76 years.

- <u>Some of the data is not statistically valid based upon the number of cases and variance.</u>

  In some of the diagnostic categories where the number of cases is very low, even one or two deaths can significantly change the overall mortality rates. These percentages may be misleading to the public, presenting a distorted perception of the actual death rate.

Although we commend any efforts to improve hospitals' quality of care, we question the use of the HCFA data for this purpose.

At St. Vincent Hospital, we will continued -- as we have in the past -- to individually review all of the cases of patients who have died here. We believe that looking more thoroughly into the care that was provided them and the factors contributing to their deaths will ultimately be of greater benefit to our patients than statistics alone.

Sincerely,

Joseph J. Neidenbach
Administrator

JJN:jmm-30

Theda Clark
REGIONAL MEDICAL CENTER

October 22, 1987

William L. Roper, M.D.
Administrator
Department of Health & Human Services
Health Care Financing Administration
Washington, D.C. 20201

Dear Dr. Roper:

I am writing to comment on the Medicare data for 1986. I was pleased to find that Theda Clark's mortality rates compare favorable to the norms you have published. However, I would like to offer some comments to assist in interpreting the information.

The HCFA data is based upon a total of 2108 Medicare admissions, counting only the final admission for the year. Our records indicate that 3301 total Medicare admissions occurred in 1986. Presumably, the balance of the admissions, 1193, were multiple admissions of individual beneficiaries.

According to the HCFA data, 184 patients died within 30 days of their final admission to the hospital during 1986. It is significant to note that of the 184 deaths listed by HCFA, 83 patients had multiple previous admissions. In other words, 45 percent of the mortalities were acutely ill patients who had already experienced multiple hospital admissions during 1986.

An additional factor that must be recognized is that of the 184 deaths listed by HCFA, 37 occurred after discharge from Theda Clark. Therefore, 20 percent of the deaths occurred elsewhere. It is unfortunately not possible to research these after discharge deaths within the current period because death after discharge is not routinely included in the patient's hospital medical record. It is important to note, however, that many patients who are known to be in the terminal stages of illness are discharged to home care, hospice care, skilled care or other appropriate settings. Many patients with irreversible terminal conditions can be appropriately treated in other than an acute care setting.

130 Second Street
Neenah, Wisconsin 54956
414/729-3100

Theda Clark Regional Medical Center
Is Operated By Theda Clark Memorial Hospital,
A Wisconsin Non-Profit Corporation.

At the risk of being overly technical, a brief comment on the statistical basis of the mortality data is appropriate. Mortality rates are calculated with the assumption that all patients admitted to the hospital within a given diagnosis category are similar and that a statistically "normal" distribution of patients exists. Theda Clark is a referral center and as such receives many complex and critically ill patients from the surrounding area. A majority of the Medicare deaths occurred to patients in the end-stages of their illnesses or at a crisis time. Of the Medicare deaths occurring at Theda Clark, 26 percent were listed with a length of stay of one day. Thus, these patients had very acute conditions and expired almost immediately. Our data also indicates that 57 percent of the deaths occurred within five days of an initial admission, again indicating the severity of the patient's initial condition.

Another indication of the acuity of the patients is the age of the Medicare beneficiaries included in the statistics. The age distribution of the patients in the HCFA report indicates that 78 percent of the deaths occurred in patients age 70 and above. This age group is known to have a higher incidence of illness and mortality.

We appreciate the opportunity to comment on the mortality statistics before they are published. The favorable comparison of Theda Clark's data to the HCFA ranges confirm my confidence in the high quality of care at Theda Clark.

If you, or others making use of the information, would like to further discuss the mortality data, please contact me.

Sincerely,

James C. Dickson
President

JCD:ss

Tomah Memorial Hospital, Inc.

Building a Reputation for Excellence

October 26, 1987

William L. Roper, M.D., Administrator
Department of Health and Human Services
Health Care Financing Administration
Washington, D.C. 20201

RE: MORTALITY RATES
Medicare Provider # 52-0144

Dear Sir:

The mortality rates for Tomah Memorial Hospital fell within the parameters in each category established by HCFA. A review of the information compiled by HCFA revealed two errors in the date of death. The correct dates of death are: [redacted] DOD: 10-01-86; [redacted] DOD: 2-27-86.

Tomah Memorial Hospital is a small primary care institution designated as a sole community provider for the rural area we serve. The number of chronically ill and aged individuals in our service area, as well as the family-centered heritage of our population which cares for its elderly at home until it is no longer possible to do so, leads to the admission or multiple admissions of patients whose prognosis is often poor.

To assure its goal of providing quality patient care, Tomah Memorial Hospital operates a system-wide quality assurance program which meets standards established by the Joint Commission on the Accreditation of Health Care Facilities. This comprehensive program provides for the regular examination of many different quality indicators to gauge performance and which recognizes that mortality review is, in itself, only one indicator which may or may not reflect quality. As part of this program, such a review is conducted by the Medical Staff on an ongoing, case-by-case basis.

Sincerely,

TOMAH MEMORIAL HOSPITAL, INC.

David Estee

David L. Hill, Administrator

DH:wo

321 Butts Avenue • P.O. Box 548 • Tomah, Wisconsin 54660-0548 • (608) 372-2181

TRI-COUNTY MEMORIAL
HOSPITAL & NURSING HOME

October 26, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

Re: HCFA Mortality Data

Dear Doctor Roper:

We are in receipt of the HCFA Mortality Rate date for Tri-County Memorial Hospital, Provider Number 520122.

In reviewing the data, we find our Hospital on the low side of the Range of Predicted Mortality Rates. Even though this would seem to cast a favorable light on our facility, we disagree with the utilization of this material as the indicator of quality of care. The two major reasons for our concern are:

1. An appropriate assessment of the hospital's quality of care performance is dependent upon many variables and requires an examination of many indicators of which mortality is but one.

2. We find it difficult to believe that this data is statistically valid for our facility due to the very low number of cases available for review. In a small hospital such as ours, one case resulting in death can indicate a 100% mortality rate.

With our own internal efforts at on-going review of quality via medical staff peer review, and our hospital-wide Quality Assurance Program, we feel we have a more accurate assessment of the quality of care provided at Tri-County Memorial.

We realize HCFA has a desire to measure quality of care and applaud same, but release of this data as the sole indicator of quality would be a disservice to our senior citizens.

We would recommend that HCFA use this mortality data as a part of a complete study of quality and release the material only after a total study is done.

Sincerely,
TRI-COUNTY MEMORIAL HOSPITAL, INC.

Ronald B. Fields,
President

RBF:ssl

1808 Lincoln Street West, Alma, Wisconsin 54773, Telephone (715) 538-4361
An Affiliate of Lutheran Health System, La Crosse

TRINITY MEMORIAL HOSPITAL

5900 SOUTH LAKE DRIVE • CUDAHY, WISCONSIN 53110 • 414/769-9000

October 23, 1987

CERTIFIED MAIL

William L. Roper, M.D
Administrator
Health Care Financing Administration
Health Standards and Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

Trinity Memorial Hospital would like to thank you for the opportunity to respond to the Selected Mortality Information which the Health Care Financing Administration (HCFA) plans to publish about all short term acute care hospitals which treated Medicare patients in 1986.

Trinity Memorial Hospital is approved by the State of Wisconsin as a 275 bed short term acute care hospital. The institution, which is located approximately nine miles south of downtown Milwaukee in the community of Cudahy, Wisconsin, provides a broad range of medical and surgical services to the communities located within Southern Milwaukee County. As a part of its full range of services, Trinity offers very sophisticated gastrointestinal services, cancer services including radiation therapy, intensive cardiac cares services, and obstetrics-gynecology services. Because of Trinity Memorial Hospital's geographic location, it also serves a large population in a very active emergency services department.

The mortality data which has been submitted to us by HCFA has been reviewed by Trinity Memorial Hospital's Quality Assurance Coordinator. Through this review, it appears as if the data accurately reflects those patients served by Trinity Memorial Hospital during 1986. Quality Review has always been and shall remain a very high priority for the entire Trinity Memorial Hospital organization. We take very seriously our responsibility for assuring that quality care is rendered to our patients through a very active clinical departmental review of not only cases of mortality, but all aspects of patient care. Because of the wide variety of quality assurance activities, the hospital's mortality data shoul be viewed as only one of many indicators of the quality of care that Trinity Memorial Hospital provides.

Again, thank you for this opportunity to comment.

Sincerely,

Kenneth V. Schreiner
President

pc

University of Wisconsin
Hospital and Clinics

600 Highland Avenue, Madison, Wisconsin 53792

Center for Health Sciences
University of Wisconsin-Madison

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Washington, D. C. 20201

Dear Dr. Roper:

The University of Wisconsin Hospital and Clinics wishes to respond to the mortality data prepared by the Health Care Financing Administration that is expected to be released in December.

University of Wisconsin Hospital and Clinics concurs with the Health Care Financing Administration that health care consumers have a legitimate interest in obtaining useful, reliable information regarding the quality of health care that is available to them. However, these particular data will be interpreted as a quality measure, despite published caveats. Therefore, it is critical that the data are accurate and not misleading in any way.

The current HCFA data are best utilized as screening mechanisms for hospital quality assurance activities. These data provide additional information for peer review processes. The quality assurance committees utilize such data to focus on specific areas where indepth medical record review and clinical experience will identify quality of care concerns. Because mortality data can be easily misinterpreted, utilizing them as public information causes confusion and apprehension.

The data HCFA provided for University of Wisconsin Hospital and Clinics indicate that we are within the expected mortality ranges with the exception of two diagnostic categories where we are slightly below the expected ranges. Despite this, we did find examples of

misleading data, and since it will be used as public information we felt these should be brought to your attention.

1. The principal diagnosis which was used to categorize the data is based on a patient's reason for admission, and frequently does not reflect co-morbid conditions the patient might present with that affect mortality; for example, an ophthalmology patient who has heart disease.

2. Within a diagnostic category the range of expected mortality for the various diagnoses is very broad. If an institution admits a significant proportion of its patients with particularly high or low mortality risk diagnoses, the statistics will be skewed. One example of this falls within the diagnostic category Metabolic/Electrolyte Disturbances. Insulin dependent diabetics with diabetic nephropathy (higher mortality) are in this category along with patients who are admitted with dehydration (low mortality).

   Even within a more specific diagnostic category such as Cancer the extent of disease is varied. Since cancer is a chronic condition, cancer referral centers often initiate treatment, however subsequent care and frequently death occur in the patient's own community. As a result mortality may be lower than expected in cancer referral centers.

3. The titles given to the diagnostic categories may be misleading. Categorizing abdominal aortic aneurysm as Severe Acute Heart Disease is an example of this.

4. The number of cases in some categories is too small to give a statistically valid, or informative result.

All four of these examples highlight the question of whether statistical mortality data without an analysis of specific patient factors such as severity of illness is an appropriate measure of quality. Since mortality data is all that is available to the public, they will utilize it for quality measurement.

We agree that the quality of patient care is a critical matter, and as a result we carry out extensive quality assurance activities at University of Wisconsin Hospital and Clinics. The Health Care Financing Administration data are useful to us in our endeavors. However, we believe that the utilization of well proven, accurate, and less misleading quality of care information for distribution to consumers is essential.

Sincerely,

Gordon M. Derzon
Superintendent

GMD:vk
0833J

VERNON MEMORIAL HOSPITAL

October 22, 1987

Health Care Financing Administration
health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

To whom it may concern:

The hospital specific mortality data, as published, was received at our hospital recently and presented to our hospital Medical Staff. Even though our mortality data fell well within the normal ranges, we felt it necessary to comment about our general reaction to the effort.

First, the actual number of admissions in our small rural hospital and each of the categories utilized was so small that a single death, regardless of cause, would have a disproportionate effect on a statistical sample. We further feel that the age categories which limit the study to the area of 65 and under, 65-69, 70-74, 75-79, 80-84, and 84 and above, is not specific enough to account for the number of deaths that would occur above 84. All deaths of patients over 85, regardless of age, are thrown together, and any hospital with a high concentration of deathes of beneficiaries over 89 will be affected the same rate as a hospital that has several deaths between 85-88 and none in the older age category. It is not uncommon for individuals from 90-100 to come to the hospital for the first time in their lives and experience a severe sudden illness and die. The statistical likelihood of someone 90 or 95 actually living another 5, 10 or 15 years in unlikely.

There are other issues that should be considered if the study continues to be considered worthwhile. The number of patients transferred back from other acute care hospitals for a hospice type of prognosis are many. There are a number of individuals who are "no code" patients, whose families have decided that due to the lack of a successful prognosis, the patient is mercifully allowed to die when the physician determines that there is no potential for life without support systems. Another issue is the necessity for separating med and surg groups to give more specific statistical meaning to the data. The transfer of patients from a nursing home, either connected to a hospital or adjacent to a hospital, or some other acute care facility should be considered in the overall survey.

In summary, our physicians and we question whether this effort is worth the time and money expended. If the data is to be used by professionsls for a critical analysis of the issues raised, it could be useful, but publication in the public press would be about as valuable as the study and publication of the reason for

507 S. Main Street Viroqua, WI 54665 608 637-2101

traffic deaths based on ages, male or female tendencies for wearing seat belts, propensities for the taking of prescription or non-prescription drugs while driving, the frequency of eye examinations, and the genetic characteristics of various races as to reaction times and athletic ability.
We appreciate the opportunity to express our concerns.

Sincerely yours,

James H. Hudson

James H. Hudson
Chief Executive Officer

JHH:rlf

Waukesha Memorial Hospital, Inc.

725 American Avenue
Waukesha, Wisconsin 53188
Telephone 414 544-2011

COMMENTS ON THE HEALTH CARE FINANCING ADMINISTRATION
MORTALITY DATA
WAUKESHA MEMORIAL HOSPITAL
52-0008
WAUKESHA, WISCONSIN

Introductory Comment

Waukesha Memorial Hospital is a 400-bed (licensed) acute care hospital located in Waukesha, Wisconsin. The hospital is a member of Waukesha Hospital System, Inc., a non-profit, two-hospital system located in -- and dedicated to -- Waukesha County.

The hospital is the largest and most sophisticated healthcare facility between Milwaukee and Dane Counties. Its service area includes Waukesha County, with a population of approximately 289,000, but it also serves patients from neighboring counties.

The hospital has a voluntary governing board comprised primarily of community representatives. The Board of Trustees meets monthly.

The hospital maintains an active and ongoing quality assurance program. This broad-based effort involves all departments, including the nursing staff and the physicians who practice at the hospital. The scope of the effort extends from comparatively simple issues such as the temperature of the food served to inpatients, to such complex issues as the appropriateness of blood transfusions or the outcome of a particular surgical procedure. All deaths that occur at Waukesha Memorial Hospital are reviewed as part of this process.

Peer review is an important part of the quality assurance process. Peer review means that nurses review nurses and physicians review physicians in a systematic process that compares the performance of an individual to a pre-established standard of care. The peer review process is designed to be an objective inquiry with comparatively little room for personal bias.

The results of the quality assurance and peer review process are reported back to the Board of Trustees of Waukesha Memorial Hospital regularly throughout the year. As representatives of the community on the hospital's governing board, members actively participate in the process, receiving detailed reports and inquiring directly about areas of concern.

HCFA Data

In each of the 16 broad diagnostic categories within which HCFA released mortality data, Waukesha Memorial Hospital is well within the range of predicted or expected death rates, as calculated for the hospital. In most cases, the hospital's actual mortality rate is at or below the mid-point of the predicted range.

A preliminary verification review of HCFA data, using the hospital's data base for purposes of comparison, indicates some variation in actual cases identified within the categories used by HCFA. These variations do not significantly alter the hospital's overall mortality rate. In diagnostic categories which showed some variation from the HCFA data, hospital mortality rates remained well within the predicted ranges. (For instance, HCFA listed a severe trauma mortality rate of 17 percent for Waukesha Memorial Hospital, on a predicted range of 2-21 percent. Hospital data verified the mortality rate at 13 percent.)

Interpretive Remarks

It is important to remember that the HCFA data represents mortality rates for Medicare patients only. Medicare eligible patients are those over the age of 65 (by far the largest proportion of Medicare patients) and individuals who are totally disabled by a chronic illness. Further, the data represents calendar year 1986 experience only.

Small sample sizes can make the mortality rate less statistically meaningful. In this regard, it is relevant to note that in nine of the sixteen categories used by HCFA, Waukesha Memorial Hospital had fewer than one hundred cases reported. In four there were twenty or fewer total cases reported. In one category, the mortality rate represented one death, which occurred outside the hospital but within the 30-day time period used by HCFA.

Some of the categories identified by HCFA, such as ophthalmologic disease, represent primarily outpatient service at this institution. The small number of cases represented in the HCFA data reflect those individuals with other complicating disease, and are not an accurate portrayal of the broad scope of the service here.

Because of the size of Waukesha Memorial Hospital, its geographic location, and its range and sophistication of clinical services, the emergency department continues to serve as a center for major trauma for Waukesha County and bordering areas. Strong surgical capability in a number of sub-specialties means fewer trauma patients are transferred. These can be contributing factors to the mortality rate in the severe trauma category.

The mortality data includes deaths which occur outside of the hospital, even though the cause of death may be unrelated to the reason for hospitalization.

These are just a few examples to illustrate that rates can and are affected by a number of variables.

Closing Comments

Waukesha Memorial Hospital understands the need of the healthcare consumer to make informed decisions about the care available to the consumer and the consumer's family.

The hospital recognizes that Medicare mortality rates may be useful to some individuals, who can -- in concert with recommendations from their personal physicians -- select the facility which might best meet their needs. Hospital selection should be based on many quality indicators, of which comparative mortality data is but one.

From the active role of the community representatives on its governing board to the ongoing and aggressive quality assurance program, Waukesha Memorial is committed to the provision of quality care for the people it serves. This commitment extends beyond the doors of the facility to the active community involvement of its physicians and staff in educational programs, legislative issues, and environmental safety issues from highway improvements to on-the-job concerns.

Within this context, the hospital encourages the people of its service area to make full use of the resources available -- including Waukesha Memorial Hospital -- in the selection of hospital services.

October 27, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
Washington, D.C. 20201

SUBJECT: Medicare Mortality Data

Dear Dr. Roper:

Thank you for the opportunity to respond to the Medicare Mortality Rates for Wausau Hospital Center as presented by the Health Care Financing Administration. We believe consumers have a legitimate interest in obtaining useful, reliable information on the quality of care that is available to them. Furthermore, we believe that the citizens of our area trust that the Wausau Hospital Center Board of Directors demand true quality assessment by our professional staff via internal quality review mechanisms.

The release of mortality data by the Health Care Financing Administration needs to be addressed as it relates to all hospitals, as well as specifically to Wausau Hospital Center. The following limitations must be recognized:

1. The mortality data by itself is not a complete measure of the quality of care provided at an individual hospital. Rather, it can be used only to better focus internal quality assurance activities. Quality judgements can be made only after reviewing the entire information provided within an individual's medical record.

2. By Health Care Financing Administration's own admission, the reliability and validity of the published data is not without error.

3. The Health Care Financing Administration's statistical model measures the relationship between a limited number of patient characteristics and the risk of death. The statistical model was not designed to consider a wide range of relevant factors that have a significant impact on mortality. Examples include: patient's general health status, severity of illness, psychological conditions, and family support.

4. In the calculation of a hospital's actual death rate, the Health Care Financing Administration has chosen to identify deaths within 30 days of admission to the hospital. This comparison results in the wrongful attribution to the hospital of deaths that may be unrelated to the condition of the patient at the time of discharge. More simply, this includes deaths that may have resulted from the management of the patient at home or in an alternate care facility.

5. The statistics released by the Health Care Financing Administration relate only to Medicare patients and not the entire universe of patients treated by the hospital.

6. A general concept to keep in perspective as noted by the Health Care Financing Administration in the Federal Register is that "the smaller the number of admissions, the less reliable are the statistics".

Wausau Hospital Center is a primary, secondary, and selected tertiary acute care provider in Marathon County, Wisconsin. Approximately 35% of our patients reside outside of the county and are referred to Wausau Hospital Center for secondary and tertiary care. As a result, the referred patients tend to represent the most acute and complex cases.

Wausau Hospital Center's Medicare Case Mix Index reflects the types of cases seen, at 30% above the national average. Given our case mix and the population served, one would predict that our mortality data would trend more toward the higher end of the expected range. However, we consistently remain in the middle to lower end of the expected range. Further clarification on three of the mortality data results must also be noted:

1. Wausau Hospital Center treats a significant number of cancer patients. One unique component of our cancer program is Hospice. Hospice by definition provides palliative care to the terminally ill patient. Accordingly, Wausau Hospital Center in offering this service recognizes it will experience mortality rates greater than other providers who do not provide this type of benefit.

2. Wausau Hospital Center provides a comprehensive approach to cardiac care. In the three diagnostic categories relating to cardiac disease, Wausau Hospital Center results are consistently within the predicted range as established by the Health Care Financing Administration.

3. It is also important to note that in some categories, such as; metabolic/electrolyte disturbances, Wausau Hospital Center treated too few patients in order for a meaningful mortality rate to be established.

Again, thank you for the opportunity to comment and it is our intent to now begin educating the public served by Wausau Hospital Center regarding this report.

Sincerely,

Paul A. Spaude
Executive Vice President

PAS/ceh

Telephone 622-3257

Wild Rose Community Memorial Hospital, Inc.

P. O. Box 243

Wild Rose, Wisconsin 54984-0243

TO: Health Standards and Quality Bureau

RE: Hospital Mortality information

FROM: Provisder 52-0149

The Medical Staff and the Wild Rose Hospital wish to make the following comments in regard to the hospital mortality information. We feel that the public will interpret this data as a measure of the quality of care, which it is not. Because of this we feel it is necessary to make the public aware of underlying facts and circumstances related to this data in order to make a fair assessment.

1. The data includes only the Medicare patient's last admission to the hospital during the calendar year 1986. In our facility a total of 413 Medicare patients were admitted and treated. HCFA's statistics include only 284 of these patients. HCFA's mortality rate of 12% in actuality, for all Medicare patients is only 6%. If the study were an accurate reflection of overall mortality , it would show that 840 patients, all payment methods included, were admitted and treated at this facility and the overall mortality rate is 3.4%.

2. Thirty-three mortalities were reported by HCFA. Of these, 26 actually expired in this facility. Seven of the 33 died after discharge, either in a nursing home, other hospital or at home -- five from known severe chronic or terminal conditions and death anticipated.

3. The average age of the 33 Medicare patients in HCFA's data is 78 years. Though an exact statement regarding 'death anticipated' cannot be made, age in itself is a significant risk factor.

4. HCFA's assignment of diagnostic categories does not reflect the actual cause of death. The final diagnoses submitted by the hospital is in accordance with HCFA guidelines, i.e. 'the principal diagnosis upon discharge is the chief reason, after study, that occasioned the admission of the patient to the hospital. Often death occurs as a result of a complication that occurred during the course of hospitalization and is not the condition for which the patient was admitted.

5. A small community hospital will transfer a patient to another acute care facility for further acute care because of lack of services, specialties, diagnostic equipment, etc. Through analysis of the data from HCFA we have identified 3 patients who were transferred to a DRG exempt facility or other government facility where the death actually occurred. HCFA has included these mortalities in our hospital, not the receiving hospital.

We feel that HCFA should develop statistical data in the future that would allow for judgements as to the quality of care based on more complex issues, such as the severity of illness, etc. The public is in need of this type of data and should not be provided with inaccurate, incomplete data that is so easily interpreted as an individual facility's quality of care. Too many conclusions can be drawn from very little information. It may be better to say nothing at all than to only provide part of the facts.

Wyoming

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
CAMPBELL CO MEM HOSP GILLETTE WY 82716	WY-5	253	18	9-19	13	38	9-55	14	43	12-58	7	29	2-59	12	33	9-56	8	25	14-73	8	0	4-60	30	27	9-39
COMMUNITY HOSPITAL TORRINGTON WY 82240	WY-6 *	344	11	8-17	15	33	16-62	7	14	9-70	11	9	4-51	11	9	8-57	12	33	13-63	10	10	2-50	49	6	10-33
CONVERSE CO MEM HOSP DOUGLAS WY 82633	WY-7 *	185	13	9-21	5	60	6-76	10	20	17-72	6	50	2-64	7	0	4-61	4	50	8-82	2	0	1-89	35	17	10-38
CROOK COUNTY MEM HOSPITAL SUNDANCE WY 82729	WY-8 *	27	19	5-33	1	100	2-99	1	0	3-99	2	0	1-89	1	100	1-97	.	.		2	0	0-89	5	40	1-68
OEPAUL HOSP CHEYENNE WY 82001	WY-9	862	10	6-13	53	19	12-37	21	33	12-50	23	17	4-36	40	28	10-35	17	41	21-65	7	57	2-60	76	17	10-29
HCA-RIVERTON HOSP RIVERTON WY 82501	WY-10 *	455	9	6-14	21	33	8-45	9	33	9-64	5	20	1-68	11	36	5-52	14	36	14-60	4	0	1-74	69	12	10-31
IHC - EVANSTON REGIONAL HO EVANSTON WY 82930	WY-11 *	134	11	6-19	3	0	2-82	1	100	0-97	7	29	1-59	8	0	4-59	6	50	10-76	5	0	1-68	19	21	8-45
IVINSON MEM HOSP LARAMIE WY 82070	WY-12 *	570	10	8-16	42	17	18-48	19	37	12-51	8	25	3-57	18	6	7-45	29	55	22-57	12	17	3-48	32	25	9-38
JOHNSON COUNTY MEM HOSP BUFFALO WY 82834	WY-13 *	160	15	8-20	13	38	7-53	6	17	7-72	8	25	4-58	11	18	6-54	2	50	2-90	5	20	1-69	16	19	8-50
LAKE HOSP YELLOWSTONE NATIONAL PARK WY 83020	WY-14 *	6	0	0-84	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
LANOER VALLEY REGIONAL MEO LANOER WY 82520	WY-15 *	408	13	8-16	30	47	13-46	10	10	6-56	8	50	4-59	25	16	8-40	16	44	18-64	6	0	1-65	40	20	10-36
MEMORIAL HOSP OF HOT SPRIN THERMOPOLIS WY 82443	WY-16	278	12	7-17	13	62	15-64	4	75	6-80	2	0	0-90	13	31	8-52	4	25	6-81	1	0	0-97	43	19	12-38
MEMORIAL HOSP OF LARAMIE C CHEYENNE WY 82001	WY-17	831	11	7-15	57	28	18-43	29	38	13-46	17	12	6-46	29	17	10-41	16	56	15-59	8	13	5-61	70	20	11-31
MEMORIAL HOSP OF PLATTE CO WHEATLAND WY 82201	WY-18 *	282	13	7-17	9	89	12-68	8	63	10-68	8	25	3-57	10	20	5-54	10	50	15-69	6	17	1-64	37	11	9-35
MEMORIAL HOSP OF SHERIDAN SHERIOAN WY 82801	WY-19	609	10	8-16	31	29	19-53	28	21	16-49	15	20	3-43	20	20	10-46	19	37	21-63	8	0	1-56	87	10	9-27
MEMORIAL HOSP OF SWEETWATE ROCK SPRINGS WY 82901	WY-20 *	468	14	9-17	29	28	10-43	14	36	9-53	7	43	3-60	20	10	6-41	21	57	22-62	13	15	3-47	74	18	12-32
MEMORIAL HOSPITAL OF CARBO RAWLINS WY 82301	WY-21 *	347	11	7-16	15	40	9-53	9	56	10-65	13	8	5-48	20	5	8-43	14	50	18-66	7	14	2-60	36	6	6-31
NIOBRARA MEMORIAL HOSP LUSK WY 82225	WY-22 *	35	11	4-28	2	50	1-89	1	0	1-97	.	.		.	.		.	.		.	.		10	30	6-56
NORTH BIG HORN HOSP LOVELL WY 82431	WY-23 *	141	18	9-22	7	57	13-76	2	50	2-90	6	0	3-65	11	36	9-58	5	100	12-83	3	0	1-81	19	16	8-45
POWELL HOSP POWELL WY 82435	WY-24 *	276	13	8-17	17	47	16-60	4	75	5-79	9	11	3-54	5	20	3-70	12	58	22-73	8	0	3-58	21	5	5-39
SOUTH BIG HORN HOSP GREYBULL WY 82426	WY-25 *	160	19	10-23	6	67	14-81	6	50	8-73	2	50	2-90	7	0	4-62	5	80	14-85	7	43	2-59	36	14	9-36
SOUTH LINCOLN HOSP OIST KEMMERER WY 83101	WY-26 *	34	24	5-29	1	100	3-99	1	0	0-97	1	100	0-97	3	33	2-81	.	.		2	50	1-89	5	40	1-68
ST JOHNS HOSP JACKSON WY 83001	WY-27 *	180	12	6-16	14	43	7-51	2	50	1-89	5	20	2-68	10	10	4-52	7	43	8-69	2	0	0-93	9	22	4-56
STAR VALLEY HOSP AFTON WY 83110	WY-28 *	60	15	8-27	4	25	2-74	1	100	3-100	1	0	0-99	2	0	1-89	8	38	13-73	2	0	0-90	8	38	6-61
VA HOSP SHERIOAN WY 82801	WY-29 *	1	0	0-100	.	.		.	.		.	.		.	.		.	.		.	.		.	.	
WASHAKIE CO MEMORIAL HOSP WORLANO WY 82401	WY-30	185	9	8-19	10	40	13-68	6	33	8-72	3	0	1-81	5	0	2-68	2	50	5-94	3	0	1-81	40	15	9-35

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
CAMPBELL CO MEM HOSP GILLETTE WY 82716	3	0	1-82	5	40	8-78	2	100	5-94	.	.		26	8	1-24	7	14	0-60	2	0	0-100	21	14	1-28	21	0	0-37
COMMUNITY HOSPITAL TORRINGTON WY 82240	4	25	6-81	1	0	2-99	3	33	0-82	.	.		39	10	1-19	15	0	1-37	.	.		24	8	0-25	26	4	0-29
CONVERSE CO MEM HOSP DOUGLAS WY 82633	3	0	2-83	1	100	2-98	1	0	0-99	.	.		30	10	1-21	4	25	1-74	.	.		8	0	0-55	6	0	0-86
CROOK COUNTY MEM HOSPITAL SUNDANCE WY 82729	.	.		.	.		.	.		.	.		2	0	0-100	2	0	0-100	.	.		5	20	0-70	.	.	
DEPAUL HOSP CHEYENNE WY 82001	3	33	3-84	3	33	5-86	17	0	2-36	26	0	0-68	113	4	2-12	47	6	1-18	5	0	0-100	92	4	2-11	68	0	0-11
HCA-RIVERTON HOSP RIVERTON WY 82501	2	0	0-91	2	50	5-93	8	0	0-54	1	0	0-100	58	3	1-15	30	3	0-24	6	0	0-100	40	5	1-18	44	0	0-17
IHC - EVANSTON REGIONAL HO EVANSTON WY 82930	3	0	3-84	.	.		.	.		.	.		12	0	0-45	4	25	0-94	1	0	0-100	17	12	1-32	8	0	0-77
IVINSON MEM HOSP LARAMIE WY 82070	3	0	0-87	3	100	10-91	18	11	1-33	2	0	0-100	72	3	1-13	72	3	1-15	7	0	0-100	19	0	1-30	53	0	0-13
JOHNSON COUNTY MEM HOSP BUFFALO WY 82834	1	0	1-97	.	.		7	14	1-58	.	.		15	7	1-35	5	20	0-68	1	0	0-100	8	13	1-53	11	0	0-48
LAKE HOSP YELLOWSTONE NATIONAL PARK WY 83020	.	.		.	.		.	.		.	.		.	.		.	.		.	.		1	0	0-100	.	.	
LANDER VALLEY REGIONAL MED LANDER WY 82520	2	100	2-90	4	75	7-82	13	8	1-40	7	0	0-99	31	3	1-22	30	0	1-23	3	0	0-100	42	5	1-17	34	3	0-22
MEMORIAL HOSP OF HOT SPRIN THERMOPOLIS WY 82443	1	0	0-97	.	.		3	33	0-87	.	.		45	2	1-18	7	0	0-61	2	0	0-100	18	0	0-31	21	0	0-34
MEMORIAL HOSP OF LARAMIE C CHEYENNE WY 82001	4	25	1-76	2	0	3-91	27	7	1-26	12	8	0-99	92	4	2-13	25	12	0-27	12	0	0-77	17	6	0-32	102	3	0-8
MEMORIAL HOSP OF PLATTE CO WHEATLAND WY 82201	3	33	1-82	1	100	2-98	4	25	0-81	1	0	0-100	35	6	1-20	4	25	0-78	3	0	0-100	22	9	1-27	22	0	0-33
MEMORIAL HOSP OF SHERIDAN SHERIDAN WY 82801	5	40	3-72	7	14	9-72	21	14	1-29	.	.		84	7	3-14	9	0	1-50	8	0	0-100	41	5	1-17	47	0	0-14
MEMORIAL HOSP OF SWEETWATE ROCK SPRINGS WY 82901	5	20	5-74	3	33	3-84	7	29	1-57	.	.		65	6	2-15	31	3	1-23	3	0	0-100	21	10	0-27	25	0	0-29
MEMORIAL HOSPITAL OF CARBO RAWLINS WY 82301	4	25	0-79	1	100	0-97	3	0	0-85	.	.		44	5	1-18	25	20	2-29	.	.		17	0	0-32	18	0	0-39
NIOBRARA MEMORIAL HOSP LUSK WY 82225	.	.		.	.		1	0	0-100	.	.		5	0	0-79	.	.		.	.		6	0	0-69	.	.	
NORTH BIG HORN HOSP LOVELL WY 82431	1	100	2-98	.	.		1	0	0-100	.	.		28	14	1-24	2	0	0-94	3	0	0-100	8	13	0-55	4	0	0-97
POWELL HOSP POWELL WY 82435	4	0	4-78	3	33	5-86	8	13	2-54	1	0	0-100	38	11	1-19	14	0	0-41	6	0	0-100	18	0	1-31	14	14	0-59
SOUTH BIG HORN HOSP GREYBULL WY 82426	4	25	4-79	4	50	7-83	.	.		.	.		20	5	2-31	5	40	0-73	1	0	0-100	12	8	1-41	3	0	0-100
SOUTH LINCOLN HOSP DIST KEMMERER WY 83101	.	.		.	.		.	.		.	.		5	0	0-80	2	0	0-93	.	.		1	0	0-100	2	0	0-100
ST JOHNS HOSP JACKSON WY 83001	2	50	0-90	1	100	3-100	5	0	0-70	.	.		20	0	1-29	7	0	0-61	3	0	0-100	8	0	0-56	22	0	0-58
STAR VALLEY HOSP AFTON WY 83110	.	.		.	.		.	.		.	.		7	14	0-60	.	.		.	.		6	0	0-73	1	0	0-100
VA HOSP SHERIDAN WY 82801	.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.		.	.	
WASHAKIE CO MEMORIAL HOSP WORLAND WY 82401	1	0	3-99	1	0	2-98	1	0	0-100	.	.		21	5	1-28	4	0	0-83	2	0	0-100	17	6	1-32	9	0	0-96

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WEST PARK COUNTY HOSPITAL CODY WY 82414	WY-31 *	397	9	7-15	24	38	13-50	6	67	6-70	6	17	4-67	15	7	10-53	8	50	11-70	6	17	2-65	41	15	7-32
WESTON CO HOSP NEWCASTLE WY 82701	WY-32 *	109	14	6-19	2	100	2-89	3	67	6-87	3	0	1-81	4	0	2-74	2	0	3-91	4	50	8-84	14	21	4-46
WYOMING MEDICAL CENTER CASPER WY 82601	WY-33	1464	10	8-14	128	20	15-34	21	29	13-50	27	26	8-39	58	14	14-36	65	34	27-51	18	17	4-42	133	19	11-26

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
WEST PARK COUNTY HOSPITAL CODY WY 82414	5	20	2-71	3	0	5-86	11	0	1-44	2	0	0-100	60	3	1-14	28	0	0-27	2	0	0-100	29	10	1-22	30	0	0-27
WESTON CO HOSP NEWCASTLE WY 82701	1	0	0-99	1	0	1-97	4	0	0-84	.	.		13	0	0-43	2	100	1-89	.	.		17	0	0-33	6	0	0-97
WYOMING MEDICAL CENTER CASPER WY 82601	14	57	8-57	8	50	10-69	42	5	3-23	3	0	0-100	156	6	2-10	96	3	1-13	17	0	0-94	102	3	3-12	115	0	0-7

*Written Comments Not Submitted.

CAMPBELL COUNTY MEMORIAL HOSPITAL

10/22/87

William L. Roper, M. D.
Administrator
Healthcare Financing Administration
Washington, D.C. 20201

RE: Mortality Statistics
Medicare Provider Number 530002

Dear Mr. Roper:

From your letter regarding the mortality statistics to be published, we have noted a statistic in particular that would tend to misconstrue mortality from our facility. I am referring to the two patients we had listed under the severe trauma category. One of these patients [redacted] had several concurrent medical problems including congestive heart failure which lead to cardiac arrest. Patient [redacted] had nineteen concurrent diagnoses while in the hospital and died later at a nursing home.

Also, since the population of the severe trauma cases (2) is so small, I feel the results (100%) misrepresent us in this case.

We also found some data errors as follows: Patient [redacted] the principal procedure should be 966. For Patient [redacted] the date of death should be 4/6/86.

Thank you for your consideration of the above.

Sincerely yours,

Elizabeth A. Jacobs, RRA

Elizabeth A. Jacobs, R.R.A.
Director, Medical Record Department
Campbell County Memorial Hospital
P.O. Box 3011
Gillette, WY 82716

cc: Joe Brown, Adminstrator
Marilyn Hogrefe, Assistant Administrator

The hospital's comments also included its written annotations to patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish these additional comments because of the numerous patient identifiers contained in these data.

DePaul Hospital

Office of the President

October 27, 1987

Department of
Health & Human Services
Health Care Financing Administration
Attn: William L. Roper, M.D.
6325 Security Blvd.
Baltimore, MD 21207

RE: Comments on the HCFA Mortality Data

Dear Dr. Roper,

The data used by HCFA indicate that a total of 82 Medicare patients admitted to DePaul Hospital died within 30 days of admission. Our own records indicate that 1,383 Medicare discharges occurred in 1986 whereas the HCFA data indicates only 862 discharges. Presumably the discrepancy reflects multiple admissions of individual beneficiaries to different hospitals. We have no way of verifying whether the number of Medicare patients treated at DePaul Hospital is correct. Without detailed information concerning the billing data available to HCFA in computing the predicted mortality rate, it is impossible to verify the accuracy of the diagnostic or other data used in your analysis.

In reviewing the HCFA mortality rates for DePaul Hospital, the individual charts of each patient were studied. Our comments relate to the 10% death of Medicare patients which is within the 6% to 13% expected range. Of the total 82 deaths, 41% or 34 patients, were admitted in the final stages of death. At that time, either the patient rejected or the family decided not to initiate measures to prolong life. The lack of nursing home beds (generally nursing homes in Cheyenne run in excess of 95% occupancy) as well as the limited skilled services available in those nursing homes, create admission to the acute care hospital setting prior to death. DePaul Hospital also provides the only Hospice services in the region. The nature of this service is such that we are caring for patients in the terminal stage of their life. These patients are then frequently admitted to the hospital just prior to death when they can no longer be cared for at home.

Descriptive comments as a result of the study of these charts indicate that 50% or 41 patients, were over 80 years old. HCFA's

mortality data did not take into consideration the severity of illness such as multiple system involvement or complications relating to the principle diagnosis. Sixty-one of these 82 patients, or 74%, were in a more advanced stage of illness, more debilitated and thereby having less chance of recovery and increasing the mortality rate.

DePaul Hospital did not exceed the upper end of the HCFA predicted mortality rate in any of the sixteen categories. It should be noted that none of the sixteen categories contained a sufficient number of cases to lend statistical validity to any conclusions which might be drawn from the data. Three of the 16 categories contained 5 or less cases and only 1 category exceeded 100 cases. Not withstanding this, DePaul Hospital was well within the HCFA predicted mortality rate in 14 of the 16 categories. There were two categories in which we approached the upper end of HCFA's predicted mortality rate - metabolic/electrolyte disturbances and severe chronic heart disease.

Metabolic/electrolyte disturbances had a 57% mortality rate or 7 cases placing Metabolic/electrolyte disturbances in the upper predicted mortality range. Of these 7 patients, 4 were admitted near death with requests that comfort measures only be administered. The average age of these patients was 85 and 5 had multiple disease diagnosis actually diminishing the chance for recovery.

Severe chronic heart disease had a 28% mortality rate, however, as the only cardiac cath center in the region, we have more referrals for this diagnosis and more seriously ill cardiac patient admissions with a correspondingly higher death rate.

Overall, DePaul has a QA program which insures the review of all deaths. Those that meet Medical Staff criteria receive further investigation, which is ongoing within the Medical Staff Department. Should questionable trends develop, study and resolution is implemented by the appropriate Medical Staff and hospital department.

Sincerely,

Sister Mary Clarice Lousberg

Sister Mary Clarice Lousberg
President

SMC/jw



TO: William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health & Human Services

FROM: Jean Pinter, RN
Acting Administrator
Hot Springs County Memorial Hospital
ID # 530004

DATE: October 22, 1987

SUBJECT: Medicare Mortality Data

Hot Springs County Memorial Hospital is a 49 bed, acute care facility. It is a sole community provider which has not-for-profit status. The Board of Trustees and the administration of the Hospital is committed to the provision of providing for uncompensated care for those who need it.

The mission statement of Hot Springs County Memorial Hospital states "... the Hospital exists to provide, within the physical limits, financial capability and human resources, the best possible primary, diagnostic, emergency and ambulatory care as well as other related health care services." It is to this end that we endeavor to provide such care to the citizenry of Hot Springs County and surrounding areas.

Through the Hospital quality assurance program, which consists of representation from the Board of Trustees, Administration, Physicians, and ancillary and/or support services departments, various monitoring mechanism are solidly in place. These mechanisms provide for the review of patients records through various sub committees to determine severity of illness, objective quality of care, timeliness, and appropriateness of all care management. Certainly it is recognizable that quality of care may be rendered but with an unsatisfactory outcome - death. There are many quality indicators; mortality is but one indicator.

Data supports the fact that Hot Springs County Memorial Hospital services a market area of primarily older Americans. The questions asked should include the age factor of the older American. It can be interpreted that the people we serve with health services find it reassuring and take great solace in the "hospice" atmosphere we provide.

In keeping with Hot Springs County Memorial Hospital philosophy of openness, it is important the public disclosure of facts is an ongoing process. The commitment of Hot Springs County Memorial Hospital will be strengthened by using this data for strategic planning endeavors. (What services can we provide to allow greater emphasis to meeting the patient and family needs?) The commitment of Hot Springs County Memorial Hospital will be strengthened by using this data for improving quality of care, (It cannot be assumed that areas of concern associated with mortality are also related to non-mortality case management).

Memorial Hospital of Laramie County
People Caring For People

300 East 23rd Street Cheyenne, WY 82001-3790 307/634-CARE (307/634-2273)

Medicare Provider Number: 53-0014

COMMENTS ON THE HCFA MORTALITY DATA
Memorial Hospital of Laramie County

Memorial Hospital of Laramie County has reviewed the HCFA 1986 Medicare Mortality Data. The Hospital has found the following errors in the information used by HCFA: date of death wrong, 2 instances; diagnosis wrong, 5 instances; procedure wrong, 2 instances. In two of the cited error incidents, the Hospital detected the errors in 1986 and requested that the Peer Review Organization correct the errors; however, the PRO apparently had not corrected the information at the time it reported the data to HCFA. The errors appear to be minor and would not substantially change any mortality rates.

The Hospital has no way of verifying the date of death in those instances where the patient died after discharge from the Hospital. The post-discharge mortality data in this study could lead to the inclusion of deaths in the mortality data that are unrelated to the reason for admission such as accidental deaths or deaths from an unrelated illnesses.

The Hospital cautions that the HCFA mortality does not consider all of the variables which will affect mortality rates. For example, Memorial Hospital of Laramie County serves as a regional hospital for the treatment of cancer patients; however, this factor was not considered in HCFAs analysis of the cancer mortality. HCFA acknowledges that its methodology does not account for intensity or severity of patient illness.

Mortality data are only a limited part of any quality assessment program. Memorial Hospital of Laramie County is very concerned with quality of patient care and has an ongoing Quality Assurance program that looks at a wide variety of quality measures, including routine and continuous monitoring of premature births, nosocomial infection rates, patient satisfaction rates, continuity of care from one facility to the next to name only a few examples.

Providing quality of care at Memorial Hospital is every employee's responsibility so that when an opportunity to improve care is identified, all levels of personnel are asked to participate in problem solving, from the Board of Trustees to individual staff members.

JD/ce

Memorial Hospital Of Sheridan County
THE HEART OF THE COMMUNITY

John Owen Yale
ADMINISTRATOR

October 27, 1987

Health Care Financing Administration
Health Standards & Quality Bureau
Hospital Mortality Information
P.O. Box 26684
Baltimore, Maryland 21207

Dear Sirs:

The Administrator, Mr. Yale, has asked me to send the following corrections of your data on this hospital's Medicare mortality information. In general, the information was accurate. Our records indicate the following changes:

ID Number	Patient Name	Change
[redacted]	[redacted]	Age 61, not 64
[redacted]	[redacted]	Age 80, not 78
[redacted]	[redacted]	Age 82, not 84
[redacted]	[redacted]	Principle diagnosis 4148, not 4140
[redacted]	[redacted]	Principle diagnosis 1534, not 4279, changing diagnostic category to CA from HL
[redacted]	[redacted]	Principle procedure 9215, not 9214
[redacted]	[redacted]	Date of death 11/13/86, not 11/14/86
[redacted]	[redacted]	Principle diagnosis 8059, not 4275, changing diagnostic category to OP from HS and adding principle procedure of 9960
[redacted]	[redacted]	Principle procedure 9642, not 9662

1401 West Fifth Street · Sheridan, Wyoming 82801 · (307) 674-4481

ID Number	Patient Name	Change
[redacted]	[redacted]	Date of death 3/23/86, not 3/25/86
[redacted]	[redacted]	Diagnostic category to TR rather than UN since patient involved in a motor vehicle accident with multiple trauma <u>including</u> fracture of a hip.

Thank you for the opportunity to review the data before it was published. If you have any questions, please contact me directly.

Yours truly,

Thomas McClain,
Assistant Administrator

TM:jr

Washakie County Memorial Hospital
Worland, Wyoming

Provider Number: 53-0022

The hospital's comments consisted primarily of annotations to the patient specific information provided by the Health Care Financing Administration to the hospital. We did not publish the comments because of the numerous patient identifiers contained in the data.

Wyoming Medical Center

J. DOUGLAS BIRD
President

1233 East Second
Casper, Wyoming 82601
(307) 577-7201

October 21, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
P.O. Box 26684
Baltimore, MD 21207

Dear Dr. Roper:

The staff of Wyoming Medical Center has reviewed the mortality statistics for our facility and find no significant errors in the data.

Wyoming Medical Center is a 282 bed, not-for-profit facility centrally located in the State of Wyoming. Wyoming Medical Center serves as the only acute care facility for the residents of Natrona County and as the principal referral hospital for most of the State of Wyoming. Through agreement with the county, Wyoming Medical Center maintains an open-door policy. Wyoming Medical Center has created programs in the fields of Cancer treatment and Cardiac Surgery not available in most other Wyoming hospitals.

We at Wyoming Medical Center believe it is important for the public to be aware of the many factors contributing to the quality of care given to patients at a facility and feel that the mortality data being published by HCFA represents only one potential measure of a hospital's quality. Other factors we believe should be evaluated are recovery rates, complication rates, services available, patient satisfaction and expected outcome as compared to actual outcome of the admission to the facility. We believe these can only be monitored by a ongoing in-house Quality Assurance Program.

Sincerely,

Linda Burdett

Linda Burdett
Vice President, Nursing

American Samoa

AS-1

Medicare Hospital Mortality Information

HOSPITALS		Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
Name/ Location	Comment/ Reference	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LBJ TROPICAL MEDICAL CENTE PAGO PAGO AS 96799	AS-3 *	153	5	4-15	4	25	5-80	6	17	5-68	2	0	0-96	4	0	2-74	2	50	4-92	2	0	0-90	32	13	6-32

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
LBJ TROPICAL MEDICAL CENTE PAGO PAGO AS 96799	.	.		.	.		1	0	0-100	7	0	0-100	15	0	0-44	3	0	0-100	.	.		14	0	0-39	6	0	0-91

*Written Comments Not Submitted.

Guam

GU-1

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	Comment/ Reference	Overall			High Risk Diagnostic Categories																				
					Cancer			Stroke			GI Catastrophes			Severe Chronic Heart Disease			Severe Acute Heart Disease			Metabolic & Electrolyte Disturbances			Pulmonary Disease		
		Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
GUAM MEM HOSP AGANA GUAM 96910	GU-3 *	293	19	10-20	14	50	14-62	28	29	13-45	7	14	1-58	28	25	10-41	8	50	13-73	8	13	4-59	43	30	10-35

*Written Comments Not Submitted.

Medicare Hospital Mortality Information

HOSPITALS Name/ Location	High Risk Diagnostic Categories									Low Risk Diagnostic Categories																	
	Renal Disease			Sepsis			Severe Trauma			Ophthalmology			GI Disease			Urology			Gynecology			Low Risk Heart Disease			Orthopedics		
	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent	Number of Patients	Actual Mortality Rate/Percent	Range of Predicted Mortality Rate/Percent
GUAM MEM HOSP AGANA GUAM 96910	2	0	2-90	2	0	4-92	6	0	0-69	3	0	0-100	20	15	2-30	16	13	1-35	2	0	0-100	24	8	1-25	11	0	0-75

*Written Comments Not Submitted.

TECHNICAL APPENDIX

METHODOLOGY

The Data Base

The basis for the present analyses is the MEDPAR file assembled and updated quarterly by the Bureau of Data Management and Strategy in HCFA. This file is constructed from information on hospitalizations submitted to HCFA by hospitals through fiscal intermediaries and from data obtained from the Social Security Administration describing certain characteristics of the patients including age, sex, race and the date of death. Because each Medicare beneficiary is assigned a unique health insurance claim number (HIC), it is possible to link hospitalizations longitudinally to ascertain prior and readmissions, and the date of death whenever and wherever it occurred.

The process of data management consisted of the following steps:

(1) admissions to acute-care hospitals were selected, as was the array of data needed to characterize the patient and the hospitalization;

(2) the first- and last-occurring hospitalizations, their nature as out- or in-transfers, and the number of admissions prior to the last of a given patient in a given calendar year were identified,

(3) patients were assigned to major diagnostic categories by means of the principal diagnoses, their additional diseases identified on the basis of the secondary diagnoses, of which there were up to four for each hospitalization, and separate files were written for each diagnostic category for the first- and last-occuring hospitalization respectively. Analyses were performed on the separate files. For the purpose of assessing overall mortality rates, results obtained for the individual diagnostic categories were aggregated. As a check on the programming, a summary file of the hospital-level data was also written and analyses of this summary file were compared with the results of aggregation of the files for the diagnostic categories.

In this project, the basis used for the assessment of mortality rates was death within 30 days of admission. However, because readmissions can occur within the interval between admission and 30 days thereafter, to avoid multiple counts of deaths, the last-occurring admission in a calendar year was chosen because it is associated with the highest risk of death. The prior experience of the patient was taken into account by identifying whether the last-occurring admission represents a transfer from another acute care facility and by identifying the overall number of prior hospitalizations in the year.

The composition of the diagnostic categories and of the comorbidities was determined in part empirically and in part on the basis of clinical judgment. The diagnostic categories used in these analyses were chosen to follow medical disciplinary lines and to report principally on high-risk admissions but also on certain low-risk admissions. The empirical testing consisted of the computation of the relative risk of death associated with the category or comoribidity compared to that isn a reference population by using standard statistical techniques (The Cox Proportional Hazards Model). A committee of clinical advisors was assembled to review alternatives and to assist in the design of an appropriate classification scheme. The approach adopted for the present analyses is the result of their deliberations and advice.

A list of the ICD9-CM codes included in each diagnostic category and comorbidity is found on the following pages.

Analytic Techniques

The principal analytical tool was logistic regression. Because the diagnostic categories are mutually exclusive, the analyses to ascertain the influence of patient characteristics (age group, sex, comorbidities, prior admissions and transfer status) were carried out separately for each category. If p is the probability of a given patient dying within 30 days of admission, its dependence on the patient's characteristics x_i (covariates) is specified by the logistic model as

$$\log \frac{p}{1-p} = \Sigma_i b_i^* x_i.$$

Once the coefficients b_i have been computed, it is possible to estimate the predicted probability of dying for that patient, and, by averaging over all the patients whose treatment in a given hospital is being evaluated, the predicted mortality rate for that hospital for the individual diagnostic category as well for all categories taken together.

The second quantity required of the analyses was an estimate of the uncertainty in the mortality rate expressed as a range of predicted rates encompassing a specified proportion (95%) of the probable values. For this it is necessary to compute the variance of the probability of death at a given hospital. This quantity is conventionally taken to consist of the sampling variance and of the variance due to the uncertainty in the estimates of the regression coefficients. The latter, given the very large populations used to estimate the coefficients, is negligible compared to the former, and was confirmed to be so by direct calculation.

	DIAGNOSIS	ICD-9-CM CODES*
High Risk		
CA	Cancer	141-160, 162-172, 174-209
CE	Stroke	430-432, 434, 436
HS	Severe acute heart disease	410, 427.1, 427.4, 427.5, 441.0, 441.1, 441.3, 441.5, 441.9, 785.51
HM	Severe chronic heart disease	398.91, 402.01, 402.11, 402.91, 425, 428, 518.4
GC	Gastrointestinal catastrophes	551, 557, 560.0, 560.2-560.9, 570, 572-572.7, 573.4, 567, 578.0, 578.9
ME	Metabolic and electrolyte disorders	250.01-250.4, 251.0, 251.1, 255.4, 276
PN	Pulmonary disease	415.1, 416.0, 480-483, 485-516, 518-519, except 516.1, and 518.4
RN	Renal disease	580-590 except 580.81 and 590.81
SE	Sepsis	DRG: 416, 417
TR	Severe trauma	806, 808.43, 808.53, 820, 821, 828, 850.2, 850.4, 851.1-851.7, 852, 839.0-839.5, 860-867, 887, 897, 900.0, 901-904, 926, 927.0, 928.0, 929.0, 942.3, 942.4, 942.5, 946.3-946.9, 947.1-947.9, 948.2-948.9, 952, 958.0, 958.1, 958.4, 958.5
Low Risk		
EY	Ophthalmologic disease	360-379
GY	Gynecologic disease	617-629
HL	Low risk heart disease	393-429, except 415.1 and 416.0 and cases in categories HS and HM
GI	Gastrointestinal disease	530-579, except 577.0, 573.1 and 573.2 and cases in category GC
GU	Urologic disease	593-609
OP	Orthopedic conditions	712-739, 810-838, 840-848 (excluding cases in category TR)
UN	All other Conditions	All other ICD 9 CM Codes

*All of the above entries refer to ICD-9-CM codes except for the entries for Sepsis which are expressed in terms of Diagnosis Related Groups (DRGs).

COMORBIDITY	ICD-9-CM CODES
Cancer	141-160.9, 162-172.9, 174-208.9
Chronic liver disease	571-572.8
Chronic renal disease	582-583.9, 585-587
Chronic cardiovascular disease	412-414.9, 426-429.1
Chronic pulmonary disease	491-493.9, 496
Cerebrovascular degeneration/ chronic psychosis	290-290.9, 294-299.9
Hypertensive disease	402-405.99, 412-414.9
Diabetes	250.01, 250.1-250.9

(A comorbidity is taken to be present if its ICD-9-CM code appears on the bill as any one of the up to four addtional diagnoses beyond the principal diagnosis.)

The sampling variance for the computation of the range of predicted mortality rates is approximately estimated by

$$[P * (1-P)]/N$$

where P is the proportion who had died of persons at risk, N, within a specified diagnostic category (or overall).

The (negligible) component of variance of the overall mortality rate, due to the regression coefficients is estimated approximately by

$$\Sigma_i[\Sigma_k\Sigma_{k'}p_{ijk}*(1-p_{ijk})*p_{ijk'}*(1-p_{ijk'})*x_{ijk}*C(b_i)*x_{ijk'}]$$

where the subscripts k and k' refer to individual patients, i to the diagnostic category, and j identifies the hospital. However, given the potential systematic differences among hospitals in the severity of illness of their patients, in the quality of care they receive and other unidentified factors, a further contribution to the variance, the interhospital variance, must be considered. This constant term is estimated by

$$IHV = \Sigma_j(P_j-\bar{P})^2*(N_j/N_t)*(1-1/N_j)$$

where P_j is the predicted mortality rate, N_j the number of cases at risk at hospital j, N_t the total number of cases at risk, and $\bar{P}$ the average mortality rate, in the category under consideration. In computations using standardized residuals, the sampling variance was based on the observed mortality rate. The difficulty engendered by the occurrence of a zero mortality rate in some hospitals was overcome by a Bayesian approximation in which the mortality rate, D/N, was replaced by (D+1)/(N+2), where D is the number of persons who died and N is the number at risk.

The ranges of predicted mortality rates given in this publication encompass 95% of the probable values on a logit scale to ensure that the range neither goes below zero nor above 100%. On the logit scale, the range of predicted values, P, is given by

$$R = \log \frac{P}{1-P} \pm 1.96 \frac{\sqrt{[P*(1-P)/N + IHV]}}{P*(1-P)}$$

Retransformed to the linear scale, the upper end of the range is

$$\exp(R_+)/(1+\exp(R_+))$$

and the lower end of the range is

$$\exp(R_-)/\exp(1+R_-)$$

where R_+ is the value of R taken with the (+) sign and R_- is the value of R taken with the (-) sign.

Two subsidiary analytical approaches were employed both as checks of the programming and the computational algorithms, and as validation tools. One was multiple linear regression in which the unit of observation was the hospital, the dependent variable the proportion of persons at risk who had died, and the independent variables within the specific diagnostic categories the proportions of the persons at risk within given characteristics used in the logistic regression. Thus, a direct comparison of the results of the logistic and the linear models was made in the case of the specific diagnostic categories. However, whereas in the computations based on logistic regression results for overall mortality were simply obtained by aggregation of the specific categories (including "Other"), in multiple linear regression analysis of this quantity, the diagnostic categories were used as covariates, along with the other patient characteristics.

The other alternative approach consisted of indirect standardization of mortality rates. The population at risk in each diagnostic category was subdivided by age-group and sex into cells within which average mortality rates were calculated. These rates were then used to compute predicted mortality rates for the age and sex-mix of each hospital.

In addition to the above, cross-validation and boot-strap analysis were used to explore the properties of the models in selected diagnostic categories. In cross-validation, the entire population at risk is randomly divided into two equal subsets and regression analyses are performed on each subset. Predicted mortality rates for the hospitals are computed both directly within each subset and by use of the patient characteristic of a given subset and the coefficients obtained in the other subset. This approach essentially tests the reproducibility of the estimation of the regression coefficients. In boot-strap analysis, replicate populations are constructed by sampling with replacement from each hospital's population. These replicate populations are of equal size but differ from each other in case-mix. Regression analyses are then performed independently on each boot-strap replicate.

Rank-order (Spearman) correlation coefficients of standardized residuals, the difference between the actual and predicted mortality rates divided by the standard error of that difference, were used to compare the results of the various analyses. In addition, the reproducibility of the identification of "outliers", hospitals whose standardized residuals were above +1.96 or below -1.96, was evaluated by ascertaining what fraction of outliers found in one year were still outliers in a subsequent year and what proportion of outliers on first-occurring admissions in 1986 were also outliers when last-occurring admission were analyzed.

SUMMARY

The tabulation of the numbers of cases at risk (i.e. the number of patients whose last discharge in 1986 was from the given hospital), of the percentage of these persons who died within 30 days of the date of admission for that hospitalization, and of the range of predicted mortality rates encompassing 95% of the probable values on the logit scale forms the core of the present publication. The observed overall mortality rates of approximately 4% of the hospitals place them more than 1.96 standard errors above the rate predicted for the case-mix of the patients of that same hospital. However, this quantity is very dependent on the precise formulation of the variance. If the interhospital variance is omitted, the number of "high outliers" rises to about 11%. In contrast, the number of "high outliers" computed by means of multiple linear regression is 2.5%. However, the variance, or more precisely, the standard error appears to behave as a scale factor affecting the shape of the distribution but to have little influence on the position of a hospital relative to the others. Thus, the Spearman correlation coefficient of residuals and of standardized residuals is about 0.95, i.e., the order is determined predominantly by the residual itself, the difference between the observed and the predicted mortality rates.

The stability of the predicted mortality rates when the case-mix of the hospital is held constant is attested to by the results of cross-validation: the Spearman correlation coefficients of standardized residuals calculated from the vector of covariates and regression coefficients estimated in the same subset with standardized residuals obtained from the same vector of covariates but regression coefficients estimated in the complementary subset are 0.99 or higher for various diagnostic categories including the most heterogeneous, cancer. In contrast, the Spearman correlation coefficients of standardized residuals obtained in successive boot-strap iterations, in which the case-mix of the hospital is allowed to vary but other characteristics are implicitly held constant, lie in the range 0.6-0.7. The implication of this last, which bears importantly on year-to-year stability of rankings, is that there remain important causes of variability in outcomes associated with variations in patient characteristics (such as severity of illness) and other factors that have not been taken into account in the models used in the present analyses.

Comparison of standardized residuals obtained by logistic regression at the patient level and by linear regression at the hospital level yields Spearman correlation coefficients that lie in the range 0.92-0.99 for the specific diagnostic categories. For the overall mortality rate, the Spearman correlation coefficient is 0.83. However, in this instance the logistic and linear model are specified differently. In the

logistic model, the results for overall mortality are obtained by simple aggregation of the results of the analyses of the specific diagnostic categories, plus the category "other", whereas in the linear model the diagnostic categories are treated as covariates. A rank-order correlation coefficient of 0.89 is also obtained when overall mortality assessed by indirect standardization is compared with the results of logistic regression. Multiple linear regression gives a convenient estimate of predictive power in the proportion of the variance accounted for by the model. For last-occurring admission and specific diagnostic categories this lies in the range of a few percent to 37%, the latter applying to the category "cancer." For overall mortality, this quantity is 59%. Almost the entire (95%) predictive power of the model for overall mortality is accounted for by ten patient characteristics: age over 85, severe acute heart disease, sepsis, pulmonary disease, cancer as a comorbidity, cerebrovascular accidents, renal disease as a comorbidity, metabolic and electrolyte disturbances, severe chronic heart disease, and age between 70 and 74.

The validity and utility of the approach used herein is best tested by comparing the results of analyses of first-and last-occurring admissions in the same calendar year and of patterns observed in successive years. When comparing first-and last-occurring admissions it is important to note that about two-thirds of hospital patients have only one discharge in a given calendar year and that one-third have multiple admissions. Therefore, some correlation will be forced by the overlap of first and last-occurring admissions. The average probability of death within 30 days of a first-occurring admissions in 1986 was 6.9% and that for the last-occurring admission was 11.7%. Clearly, these hospitalizations are associated with very different risks. For 1986 discharges, the Spearman correlation coefficient of standardized residuals for first-and last-occurring admissions was 0.83. In addition, about two-thirds of the hospitals identified as high outliers for first admissions were also high outliers based on analysis of outcomes of last-occurring admissions (71% if the interhospital variance term was not used in the calculation of the standardized residual and 64% if it was).

The Spearman correlation coefficients of standardized residuals for last-occurring admissions in 1985 and 1986 were 0.61 (0.57 if the interhospital variance component is included in the variance) and 0.51 (0.48) when 1984 and 1986 rankings are compared. The concordance of high outliers in 1985 and 1986 was 48% and for 1984 and 1986 it was 44%.

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